The Contribution of General Practice Placements to Medical Education: An Analysis of the Construction of General Practice Placement Knowledge in Published Medical Education Research

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Declaration and word count:

I, Sophie Park, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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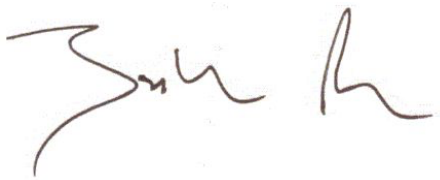

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Abstract

This thesis examines the dominant discourses within research texts about undergraduate general practice placements. This makes visible what is said to be taught and learnt in placements; how research about placements is justified; and how these characterisations produce particular ways of being and knowing for subjects.

Analysis examines rules of acceptability and discursive assumptions, exploring the 'thinkable' and 'unthinkable'. This process uses categories of object, subject position, concept and strategy, to build a map of ways in which texts characterise placements; how this produces particular ways of being and relations between students, patients, GPs and researchers; how these link with ways of conceptualising learning; and how overall strategies produce power relations.

Two ways of characterizing placements are identified. A 'gaze of discovery' views placements as opportunistic experiential learning with patients, producing possibilities for patients as 'educator' and 'contextualised disease'; GP-teacher as 'facilitator'; and student as 'participatory learner' or 'intruder'. A more dominant 'gaze of deciphering' treats placements as pre-determined curricula compartments using mind-body and knowledge-skills-attitude distinctions to imagine different learning in different spaces. Placements are treated as basic, early or filling gaps in hospital-based curricula. This produces patient as 'subject with x'; student as 'learner of curriculum'; and GPs as 'teacher *or* clinician' and 'not knowing'.

Evaluation is the dominant way of justifying research, positioning placements as innovative (and thereby un-established) and researcher as 'evaluator', distinct from clinician-teacher. Other texts justify research as 'making voices heard', some legitimising co-construction of knowledge with participants, and an integrated position for the researcher-practitioner.

Overall, strategies position placements as supplementary and different to hospital teaching. Justifying research as evaluation produces challenges for the legitimacy of the field, in relation to other research. While teaching is treated as exchange of existing knowledge, research is positioned as informing teaching practice, legitimising its value through production of new knowledge.

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I am enormously grateful to all my colleagues and peers who have produced the texts which form the basis of this analysis. I hope they will find this thesis of interest and use in informing future directions for research texts and determining further research agendas.

Finally, enormous thanks to my family (especially my husband Alistair, and children Lottie, Tobias and Raphy) and friends, for their depth and longevity of support and patience in helping me to complete this Doctorate.

In memory of my father, Derek Frankland, who died on 9th February 2017 aged 89,
and who dedicated his life to education.

Chapter 1 Introduction

Researching General Practice Placements

This thesis examines how published research texts about UK general practice placements are characterised and how this research is justified. This thesis addresses two research questions:

Within published research texts about UK general practice placements:

- What is said to be taught and learnt in general practice placements? and
- How is the production of research justified?

I have chosen a Foucauldian approach to discourse analysis, in order to examine the treatment of knowledge and subsequent power relations in research texts about general practice placements. Foucauldian discourse analysis provides a critical lens to examine how possibilities for the thinkable are made legitimate, or constrained, within texts. Examining the 'thinkable', also makes space to consider what is 'unthinkable' or unintelligible, and how this produces particular possibilities for practice, power and status. This thesis examines not only how it is thinkable within these texts to characterise general practice placements, but also to justify the production of research. I consider how justifying research in particular ways, relates to particular ways of characterising placements. Examination of how justification of research is made thinkable within this discursive field also provides a helpful basis from which to consider how this field contrasts or inter-relates with other fields of research (such as medicine or education), and power relations between the two.

A Foucauldian approach enables critical examination of assumptions or normative ways of thinking. It makes visible how each utterance is made within specific discursive boundaries, to which certain rules of acceptability apply (Andersen, 2003). This makes curious how and when something becomes treated as a general practice placement or research, and when not. Rules can be fluid and change over time, or indeed overlap creating tensions and fluctuations in how things are made visible or thinkable. These rules produce particular power relations: treating as normative particular ways of seeing or being, and marginalising others. This analysis of research texts about general practice placements examines how placements are made thinkable within these texts: what knowledge is said to be available to be taught and learnt? And how particular rules govern the ways in which research is

justified. These rules concern not only how placements and research are characterised as legitimate or acceptable, but also how particular subject positions are made available within those constraints. How is a position produced for a legitimate researcher, or how is a position produced for patients within the general practice teaching encounter?

Research texts are one important object or artefact of 'work' within the professional world of general practice medical education, with and to which the academic community is expected to engage and contribute. From what position these texts are produced and what is valued within the texts as legitimate research, are questions that shape relations of power within the academy. These relations of power shape the status of individuals, universities and this research field in relation to others. Published research papers are used within the academy to determine the economic and political status of individuals and universities within matrices of measurement criteria informing academic promotion and participation in the Research Excellence Framework (REF) (Apple, 2006; Ball, 2013; Barnett, 2006), medical education research, for example, often being described as the 'poor relation' of medical research (Todres, 2007).

There is debate about the extent to which research shapes practice and policy (Hammersley, 2007) (Hammersley, 2013). Research texts are, nevertheless, an important available source used to inform discussions about practice and policy. Examining how placements are researched and how this shapes knowledge about placements produced in research texts is therefore helpful to understand not only in the context of producing future research, how this might be conducted and the power relations this might produce or support, but also how this field might contribute to or interconnect with discussions about practice and policy. Analysis of how placements are characterised within research texts might therefore, for example, create spaces for thinking differently (Hodges, 2007) about current political debates surrounding recruitment of trainees into general practice, thought to be related to students' undergraduate experiences; and recruitment of GP tutors in the context of increasing service demands.

Research texts are treated within this thesis as a social practice. Other researchers have analysed research texts as a social practice. Albert, for example, used Bourdieu's concept of 'field' to conduct an analysis of medical education research (Albert, 2004). He examined how medical education research as a social practice is socially constructed through socio-historical circumstances and power relationships within social groups, and how particular definitions of research excellence have come to predominate and shift within a community of

researchers over time (Albert, 2004). In this thesis, my analysis does not attempt or claim to examine meaning *behind* the text. Rather, I aim to examine how meaning is constructed *within* the research texts, producing a map or topography of what is thinkable within the discursive field of research texts about general practice placements in UK undergraduate medical education. No-one, to date, has examined in this way what is said to be taught and learnt in general practice placements, or how research about this is justified.

During my analysis, I have drawn, in particular, on two books by Foucault. The first, 'Birth of the Clinic', uses the concept of 'gaze' to examine how 'the body' and 'the clinic' were made thinkable over time (Foucault, 1973). The second book, 'Archaeology of Knowledge' (Foucault, 1976), examines the ideology of 'science' as a system of formations (objects, subjects, concepts and strategies), treating science as one possibility among others (Lather, 2010). Foucault examines text as a social practice. His approach changed over time and he resisted any one formula being used to describe his analysis. His analyses were, however, consistently concerned with relations of power and how these are constructed and maintained.

Many different approaches have been used to operationalise a Foucauldian approach to discourse analysis. I have drawn, in particular, on texts by Andersen and Howarth to define my method (Andersen, 2003) (Howarth, 2000). My analysis produces a map of the discursive field (Foucault, 1972) or discursive practices (Howarth, 2000, p. 52) of research texts about general practice placements. I have done this constructing an archive of texts using electronic search databases to identify texts (which date from 1960s and 1970s onwards) about UK general practice placements. I have used a process of iterative critical case selection to identify statements within texts to make visible the range of a ways in which placements are characterised and research justified in this field. I began by selecting a range of texts published over different decades of my archive, looked for contrasting cases, then re-visited texts to refine and develop my analytical thinking. This process involved reading and re-reading texts to familiarise myself with papers, beginning to note similarities and contrasting aspects. I examined texts using four analytical categories: how the *object* of general practice placements are characterised; what *subject positions* are produced or made available; what *concepts* or logics are used; and what *strategies* do these produce? I have used instances or examples of texts to illustrate my analytical categories within the results chapters.

In summary, this thesis makes a contribution both to my own professional development as a novice educational researcher understanding the field in which I am situated, and more broadly to professional knowledge mapping what is thinkable as a way of informing future ways of characterising placements in research, choosing methodologies and positioning researchers within this field. This thesis uses an innovative methodology, little used in medical education research and never previously used in primary care medical education research, to produce new knowledge and insights in relation to this methodology. This analysis makes a contribution to configuration of a whole research field, making space to reconceptualise that field and supporting reflexivity about how placements are characterised and research justified. I am an insider researcher situated within this field of research. Others may, therefore, see or make visible other analyses not visible to me in relation to these questions and this field of research texts. Being an insider has, however, helped me to keep my analysis relevant to the community I am researching for and with.

General practice and medical education

In this section, I will outline some of the key historical events in the relationship between medical education and general practice. I will then go on to discuss some of the current issues concerning the community of general practice medical education. As a practising GP and senior lecturer in a university, I am embedded in this professional world: an 'insider researcher'. I hope, therefore, that this account will provide some useful background for readers unfamiliar with general practice medical education, but also frame my understanding of the history and current concerns in this professional context, shaping my approach to analysis.

One of the first key events shaping the relationship between general practice and undergraduate medical education within the UK was the Medical Act in 1858 (GMC, 1858). Its primary aim was to allow the public to distinguish between 'qualified' and 'unqualified' practitioners (GMC, 1858, p. 1) . This agreement, however, also marked the division of specialists and generalists. Specialist surgeons and physicians held hospital and university (medical school) posts, while GPs took ownership of patients (Park, 2014a).

While many of these hospital-based specialities went on to form Royal Colleges and subsequent examinations marking professionalisation within those disciplines, it was not until 1953 that the Royal College of General Practitioners was founded. Foundation membership was offered to those GPs who satisfied specific criteria – with over 1600 GP members within 6 weeks of the college being established (Tait, 2002). A publication entitled

'the Future General Practitioner' later attempted to make explicit the specific knowledge and role of the GP, presenting an argument for the recognition of general practice as a specific postgraduate training route in medicine (RCGP, 1972). This came to fulfilment in 1976, when parliament approved legislation making vocational training a requirement for any doctor seeking to become a principal in general practice. It was not, however, until 2007 that the MRCGP exam (then entitled the new 'nMRCGP') became compulsory for GPs wishing to practice independently following postgraduate training.

At an undergraduate level, the hospital and university had been the location for training throughout the 19th and early 20th century. A significant division between the university and the hospital came about following the publication of the Flexner Report in 1910 (US version and later 'Medical Education in Europe' 1912) (Flexner, 1910). This marked the global adoption of pre-clinical and clinical undergraduate curricula, dividing teaching and learning about science and clinical knowledge. It was not, however, until the 1960s, that general practice placements became a formal component of undergraduate teaching.

Soon after the foundation of the Royal College of General Practitioners came the GP charter in 1966. This marked the beginning of a new shift in the relationship between general practice and undergraduate medical education. In 1967, the GMC made recommendations for basic medical education, stating that each medical school should identify 'growing points' for the undergraduate teaching of general practice (GMC, 1967). In 1968, came a Royal Commission on Medical Education (or 'the Todd Report'), which highlighted the lack of social and behavioural sciences in undergraduate curricula, recommending formation of university departments and academic appointments in public health, social or community medicine (Howie, 2011; Todd, 1968). The funding for these departments became more explicit in 1992 with the advent of 'tasked' money from health authorities to university departments and 'SIFT' (service increment for teaching).

In recent times, there have been a number of policy documents and reports recommending that students spend more time in the community setting. These include international reports about curriculum reform in the 'Edinburgh Declaration' (WFME, 1988; WFME, 1994b) and within the UK, the King's Fund report (Towle, 1991) and a policy document entitled 'Tomorrow's Doctor's' produced by the General Medical Council (GMC) (GMC, 1993b). The publication of 'Tomorrow's Doctors' marked a significant shift in the relationship between general practice and undergraduate medical education. It emphasised the importance of community-based education, as well as the integration of clinical and scientific knowledge

within curricula. While further iterations of this document have developed and changed the nature of the recommendations, it was, at the time, a landmark document setting out radical changes in the priorities and focus of undergraduate medical education (Park, 2012a). Its broad objectives set out to encourage an integrated, systems-based approach to medical education with a greater emphasis on human, communication and public health aspects of the curriculum; acknowledging the importance of primary care in teaching; and recommending a core curriculum for diverse professional opportunities in medicine (GMC, 1993b).

Currently, medical students in the UK experience between 3 and 15% of their undergraduate training in the general practice setting (Jones, 2008; Park, 2015a; Park, 2015b). This figure has recently been shown to be declining: a cross-sectional survey of medical schools finding that the total amount of general practice teaching per student has fallen by 2 weeks (from an average of 122 sessions to 102) since 2002 (Harding, 2015). Many reports have expressed disappointment that undergraduate curricula remain fundamentally hospital-based (Pearson, 2010), with repeated on-going attempts to increase provision of undergraduate general practice teaching. Over 20 years ago, Julian Tudor Hart argued that the (then) 3:97% split in time medical students spent in primary and secondary care during medical training should be reversed (Hart, 1985). Since then, a number of rationales have been used to support arguments for expansion of general practice-based teaching. One rationale has been that the proportion of undergraduate general practice teaching should reflect the service shift in patient ‘load’. Ninety per cent of patient encounters are said to take place in primary care (Green, 2001), with earlier hospital discharges, shorter stays and more outpatients treatment, moving the ‘patient teaching resource’ into the community treatments (Sen Gupta, 2001) (DOH, 2000; DOH, 2006).

There are significant financial barriers to the expansion of undergraduate general practice placements. Funding sources for undergraduate education are complex, and originate from both the Higher Education Funding Council (HEFC) and the NHS (BMA, 2007). A major component of direct funding for clinical teaching is SIFT (service increment for teaching). SIFT was designed to support ‘the additional costs incurred by NHS organisations in providing clinical placements for medical undergraduates in England’, but it is not a payment for teaching (BMA, 2007). Prior to the publication of the Winyard Report (Winyard, 1995), SIFT payments were not generally made for community placements, with general practices receiving a set payment from the Family Health Services Authority (FHSA) (Beecham, 1995). Since 1995, very few general practices have been able to access the larger ‘facilities’

component of SIFT which were traditionally reserved to support the infrastructure of large NHS teaching trusts or hospitals (Pearson, 2010), prohibiting further investment in general practice placements. There have been recent attempts to address these funding issues with the publication of a House of Commons Health Committee Report on Primary Care (2016), which recommended that SIFT funding be reviewed by 2017, to reflect the 'true costs of training' in the general practice setting (Committee, 2016).

Recruitment into general practice training has been a significant issue contributing to recent discussions about funding improvements. Lambert and Goldacre's longitudinal study of UK Medical Careers have shown that only 20% of doctors in their first year after qualification express a first choice career preference for general practice (Lambert, 2011), despite Department of Health expectations that 50% of newly qualified doctors each year should be recruited to general practice (DOH, 2008). Similarly, attention has been drawn to the 20% of GPs over the age of 55, likely to retire in the next few years (CWI, 2010). This has resulted most recently in a collaborative report by NHS England, Health Education England, the Royal College of General Practitioners and the British Medical Association's GP committee (GPC) promising investment in 'primary care infrastructure' which they claim will 'enable increased training capacity and a more positive experience for medical students and foundation year doctors within general practice' (Snow-Miller, 2015, p. 5).

Difficulties in recruiting and retaining GPs have been linked with debates about undergraduate general practice placement provision. Undergraduate exposure to general practice has been shown to positively influence future career choice (Harding, 2015), some suggesting placement time should be increased to address 'lack' of uptake into general practice careers (Snow-Miller, 2015). Attention has, consequently, been drawn to the quantity and nature of undergraduate general practice placements amid discussions of a current 'crisis' in GP recruitment (Peters, 2008; Rosenthal, 2011; Millett, 2015). These debates raise questions about the type of knowledge expected to be taught and learnt in general practice placements. Some assume that what is taught in placements reflects GP service in the clinical work-place (Pearson, 2010). There are, however, a variety of ways in which students are now reported to be taught in the general practice setting (Park, 2015b). These include reports of general practice teaching in the early 'pre-clinical' years (Dornan, 2006), and reported increases in general practice placements providing specialist teaching (Peters, 2008). This thesis contributes to these debates through examination of what is said to be taught and learnt in general practice placements, within the discursive field of research texts.

Thesis Structure

Production of this thesis has been a long and at times painful process, but also exciting and fulfilling. I hope it marks the beginning of a lifelong critical professional conversation, rather than a definitive endpoint. There have been many iterations of this analysis: my analysis developing during the writing and feedback process. I have tried many different ways of organising my writing, each iteration helping to further clarify and develop my analysis. I hope this final structure is accessible and useful for the reader, sharing a coherent narrative of the research. I begin with this introduction, which outlines the rationale for this thesis and my understanding of the context for this research, including medical education in general practice placements, and production of research publications within the university academy.

Chapter 2 describes my methodological approach and the way in which I have conducted this method. There are then three 'results' chapters. The first two chapters address the question about what is said within these texts to be taught and learnt in general practice placements. These chapters are divided into two contrasting 'gazes' or ways of characterising placements. I have drawn upon terms used by Foucault in 'Birth of the Clinic', naming these as a 'gaze of discovery' and a 'gaze of deciphering'. Chapter 5 addresses the research question, asking how the research is justified. In each of these chapters, I identify how the object is characterised; subject positions made available; and concepts or logics used. In Chapter 6, I bring these results together to discuss how this discursive field produces overall strategies, and how justifications of research and characterisation of placements relate. There is not one unified or coherent way in which research is justified and general practice characterised, but I discuss the dissonances within my analysis, and how particular ways of thinking are made dominant within this field. I also discuss within this chapter how these strategies relate to alternative and wider discursive practices in research literature about educational and medical educational research. The final chapter then provides a reflexive post-script to the research process; and both considers my position as a researcher in this thesis and how this thesis might shape my professional future.

Glossary of Terms

Throughout this thesis, I use a number of abbreviations listed below. In the analysis chapters, I have used **bold type** to draw the reader's attention to particular aspects of the included quotes. These are my emphasis to support the reader's understanding of my analysis and not included in the original publications. I have at times used '…', to mark

where I have needed to edit an included quote to highlight an analytical point, within the constraints of the thesis word count.

MRCGP – Member of the Royal College of General Practitioners

RCGP – Royal College of General Practitioners

IFS – Institutional Focused Study (part of the EdD)

BEME – Best Evidence in Medical Education

BICC – BEME International Collaboration Centre

REF – Research Excellence Framework

FDA – Foucauldian Discourse Analysis

Chapter 2: Methodology and Method

Within this chapter, I outline my methodological and theoretical approach, then the operationalisation of the method used to conduct this thesis. Foucault's work underpins both the theoretical and specific method I have used in this thesis. I have, therefore, positioned both methodology and method within this chapter.

Methodology

Foucauldian Discourse Analysis (FDA) and social constructivism

Within this thesis, I have conceptualised published research texts as socially-situated and complex. I have, therefore, constructed my methodology to acknowledge the context-bound nature of education and research production. This thesis uses a Foucauldian approach to discourse analysis (FDA) to examine how general practice placements are treated in published research texts. I am interested in examining how this discursive field produces possibilities for what can be thinkable as taught and learnt in the general practice setting. This is closely connected with the ways in which knowledge is allocated and said to be available in general practice placements. Within a social constructivist lens, knowledge is understood to be a socially constructed object, shaped by culturally and historically determined preoccupations. This approach allows us to conceptualise knowledge as a construction or product of language. Language is understood to be contextualised, shaped or framed within particular 'ways of seeing', 'ways of understanding' or 'discourse' (Andersen, 2003). The role of language in the creation of knowledge then becomes a key research focus as a way of understanding which 'ways of seeing' or discursive practices have shaped the production of language used and why.

There are many different ways of understanding and operationalising discourse analysis (Potter, 1987). Further, there are multiple ways of conceptualising and using Foucauldian approaches to discourse analysis in research (Mayo, 2000). Foucault was not explicit about many aspects of his 'methods', in fact, changing his approaches over time. Many have attempted to make his methods operationalisable for others. My own approach has been influenced most closely by Howarth and Andersen (Andersen, 2003; Howarth, 2000). Both provide useful critical questions to ask of the text, while acknowledging that there are 'gaps' in Foucault's descriptions, and ambiguities about application particular to a research context at a particular time. Rather, then, than presenting an assumed coherence within this thesis, I have included some of the challenges and ambiguities I have encountered when using FDA

with these texts. I discuss later in this chapter, for example, how I found both the application of analytical 'categories' to the specific context of these texts, and decisions about how to express and structure my analysis, far from straight forward.

Many sociologists use discourse analysis to extrapolate meaning about social practices *behind* the text (Butler, 1999) . This analysis focuses upon how meanings are realised textually. The claims of analysis, then, address the treatment of categories *within* the texts themselves. The text is not understood as a transcription of reality *beyond* the text, but the text itself is the focus and the research questions orientated towards how reality is produced and made productive *within* the text. This analysis does not assume a direct correspondence between the labels given to phenomena and a social reality or 'what is really there', but seeks to understand the cultural and historical ways in which language use has been shaped. Language texts, can therefore be viewed as artefacts of institutional arrangements within particular contextual constraints of time, place, social and economic arrangements of that society (Chinn, 2006). During my analysis I was not attempting to attribute meaning to the text by asking 'what is the meaning of x', rather '*how* is meaning constructed within the text'?

In Foucault's later work, his analyses attend not only to the archaeology or 'rules of formation' which structure discursive practices, but also the genealogy or historical emergence of discursive formations. This latter approach makes possible examination of the exercise of power and 'systems of domination' within texts, which produce certain perspectives as acceptable, thinkable, 'normal' or dominant, and others unthinkable, unacceptable or marginalised (Howarth, 2000, p. 49). Foucault articulates this combination of approaches examining both the rules and emergence of discursive formations as 'problematisation' (Howarth, 2000, p. 50) (Foucault, 1985, pp. 11-13) (Foucault, 1984, pp. 388-90). This approach to analysis encourages the researcher to step back and critique or problematise accepted ways of seeing; ways of constructing and addressing problems; and ways of legitimising and marginalising available subject positions (Andersen, 2003). A particular discursive practice will, for example, determine what questions are possible to ask in a particular time and place. The analysis can explore how the text produces power or status for particular knowledge or subject positions through making certain issues visible within a particular frame of thinking, while others remain invisible:

"What I tried to do from the beginning was to analyse the process of 'problematisation' – which means: how and why certain things (behaviour, phenomena, processes) become a problem" (Foucault, 1983)

This curiosity about *how* something is problematised is an important aspect of my thesis. I have constructed my own research questions to problematise how general practice placement are researched, making curious the nature of knowledge said to be taught and learnt in this setting. Within my analysis, I examine how published research texts problematise, position and produce this knowledge making visible certain ways (and invisible others) of characterising, conceptualising and constructing particular strategies about general practice placements, producing certain power relations within the texts.

Power/knowledge

One area of analytical interest for Foucault was the relationship between power and knowledge. Whereas some forms of sociological analysis, such as work by Bourdieu, are based upon an understanding that analysis reveals pre-existing power and social relations formed prior to speech, Foucault maintained that discursive practices and social relations did not exist outside the statement (Butler, 1999). Foucault maintained, for example, that power was not a possession *held by* the institution, but rather a strategy negotiated through discourse and the treatment of knowledge (Bristowe, 2014, p. 552):

"It is in discourse that power and knowledge are joined together." (Foucault, 1979b, p. 100).

Foucault understood these two elements not as separate, but inter-related elements of a discursive practice. In this thesis, this provides a critical perspective from which to examine how treatment of knowledge produces power in particular ways. Further, through highlighting how a discursive practice prioritises or legitimises particular ways of thinking, it facilitates questioning about how alternative treatment of knowledge might produce power in alternative ways:

"It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power." (Foucault, 1980a)

This focuses analysis not towards the subject or their intention during negotiations of power, rather towards the contextual discursive practices in which subjects participate, shaping the

boundaries of possibility – who is able to speak; from where; and in what way (Andersen, 2003, p. 15) (Howarth, 2000, p. 53)? Power is not understood as something outside of, or imposed onto the text, but constructed within the text and the ways in which it adheres to particular discursive practices. Through the process of analysis, the relations between the treatment of general practice placement knowledge and power become articulated. FDA enables an examination of particular discursive practices and ways in which the rules determine possible and impossible ways of thinking. These 'rules' are intimately linked with opportunities for and resistance to power, producing an inter-play of knowledge and power, making possibilities for constituents of that discursive practice to be made thinkable or not. These rules may remain regular or continuous ('continuities') for many years, or change, producing discontinuities within a discursive practice (Foucault, 1979a). Thus shifts may occur in what is treated as thinkable or not, and related power relations, over time (Hodges, 2012). These shifts are not necessarily temporally linear - different ways of thinking may be possible contemporaneously, but some treated as more legitimate or acceptable than others in a particular time and place (Hodges, 2012):

> *"We must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies.... Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it." (Foucault, 1979b, pp. 100-1)*

Birth of the Clinic

In his book 'Birth of the Clinic', Foucault describes the shift in medical practice and teaching, and the related changes in power and status of the doctor, when medical practice becomes framed in the late 18th century as 'seeing', or a 'medical gaze' (Foucault, 1973). This gaze, he notes, is organised around a nosology of disease, including spatial organisation of the hospital into disease categories. This includes examination of the Cartesian split of mind and body, elevating the doctor to the prior role of the priest and positioning post mortems as a culmination of life and seeing into an individual's body. It is not until his publication of 'Archaeology of Knowledge' that Foucault provides specific details of his 'method' approach to discourse analysis, which I have used to inform my categorising of texts during analysis (Foucault, 1974).

Foucault does not describe his earlier work 'Birth of the Clinic' as a 'discourse analysis', but presents an analysis of the discursive field of Medicine, and its orientation towards the production of a way of seeing or 'gaze'. He shows how, in a particular time period, medical practice and teaching in hospitals were thinkable and unthinkable. I have used this concept of 'gaze' in the way in which I have drawn my analysis together in chapters to present overall continuities and discontinuities. It was not until the later stages of my analysis that I revisited the 'Birth of the Clinic' text and drew specifically upon his naming of a gaze of discovery and deciphering as relevant to use in my own analysis of the discursive field of research texts about general practice placements.

Body of knowledge to which this thesis contributes

This thesis could be classified as a critical 'literature review'. I have not, therefore, included a formal chapter on 'the literature'. This section, however, builds upon my rationale in Chapter 1, outlining the body of literature to which I think this thesis can contribute, first in terms of topic, then method.

Literature about general practice placements

I have used many of the topic-related research papers as my data for analysis. There are, however, some additional papers that have not used primary research methods but are relevant here in their discussion of the nature of general practice placement knowledge. Bleakley and Brosnan both highlight the importance of understanding how knowledge has been situated within a particular setting or course, drawing particular attention to curricula design. Both have relevance to this thesis and its exploration of the ways in which what is said to be learnt and taught in placements are treated within research texts. Bleakley, in his editorial 'curriculum as conversation' emphasises the importance of knowing authors' values, which permeate research and curricular texts. He encourages readers to consider issues of legitimacy and power including how a curricular course was set up; and who decides what and how the course shall be and on what grounds (Bleakley, 2009, p. 299). Brosnan in her 'Handbook of the Sociology of Medical Education' also draws attention to the importance of understanding the character of knowledge and distinctions between knowledge in different settings and between professional groups, as key to debates about curricula change and development (Brosnan, 2009b, p. 10).

Harden produced a 'SPICES' theoretical model, based upon his experience of different medical education undergraduate courses, to demonstrate and discuss the dyadic possibilities of medical curricula (Harden, 1984, p. 285), many of which are relevant to this

thesis and its examination of the characterisation of general practice placements in research texts:

- Student-centred ➔ teacher-centred
- Problem-based ➔ Information gathering
- Integrated ➔ Discipline-based
- Community-based ➔ Hospital-based
- Electives ➔ Standard programme
- Systematic ➔ Apprenticeship-based or opportunistic

Several of these distinctions are relevant to examining the ways in which general practice placements are treated within the research literature, as well as what subject positions become available as a result. First, I attend to the community-hospital division. Using a Venn diagram, Harden describes the possibilities for learning located in either or both settings as 'experiences gained only in the community'; 'experiences gained only in hospital'; and 'experiences gained in hospital or in the community' (Harden, 1984, p. 292). The first category is treated as the need for continuity of care; the effect illness has on the family; the early signs of disease; and the spectrum of health problems not normally seen in hospital. The second category is treated as major surgery; less common diseases; and investigative procedures (Harden, 1984, p. 291). The author does not, however, describe what might fall within the final category of experiences available across both settings.

A second distinction is made in the SPICES model, between integrated and discipline-based curricula. This distinguishes curricula which separate academic courses, disciplines and departments (e.g. as anatomy, biochemistry, pathology, community medicine, surgery and so on), or attempt to inter-relate or unify subjects (Harden, 1984, p. 288). A particular space can, then, be associated with multiple forms of knowledge, or a specific area of the curriculum. This allocation of knowledge has been described as producing polar distinctions, where that knowledge is considered available as a topic or unavailable as a 'non-topic' (Suzuki, 1974, p. 483).

A third distinction in the SPICES model is between systematic and apprenticeship-based curricula. The author distinguishes a traditional apprenticeship-type model with a modern planned, monitored and systematic approach where 'what the students do and see should no longer be left to chance' (Harden, 1984, p. 295). Harden promotes systematic curricula as providing a range of experience, and rationalisation of competencies and time. He treats

the advantages of apprenticeship models as organisationally easier and providing continuity of teaching. He does not mention the different knowledge(s) these models might offer, or the tensions they might create in provision of teaching and service.

This move towards 'systematic' rather than apprenticeship-type models of learning has been widespread across medical education, with significant shifts towards standardisation (Jolly, 2004) and competency-based models of education (Park, 2012a). Jolly writes about the positioning of general practice education within this systematic model. While acknowledging that 'no two medical students ever get the same 'course' (Bennard, 1989; Jolly, 1996; Mattern, 1983), he proposes that variability within curricula be minimised wherever possible: 'most schools are realising that in a modern curriculum as little should be left to chance as possible; to do so results in students with very disparate skill bases' (Hunskaar, 1983; Jolly, 1989).

The inclusion of general practice in undergraduate medical curricula is not always positioned as an active educational choice. Jolly, for example, positions general practice teaching as a necessity of the changing nature of hospital-service provision. He highlights the changing role of general practice and reduced patient stays in high-tech hospital environments contributing to this shift. He treats the move towards primary care orientated curricula with caution, describing it as a 'loss of power to hospital-based specialities.' (Jolly, 2004, p. 26), and highlights the challenges to providing medical education in this setting: '[they] may have a greater number of patients but be restricted by their lower level of differentiation and specificity.' (Jolly, 2004, p. 27).

Literature about using Foucauldian Discourse Analysis in medical education research

I now turn to some of the methodological literature to which this thesis relates. Mann highlights how ways of thinking about and researching medical education have changed over time and engaged different discursive practices (Mann, 2011). She draws attention to the emergence of framing medical education as a socially situated, contextual practice, with a burgeoning field of medical education research, to which I think this thesis contributes, using theories such as communities of practice (Wenger, 2010) and workplace-based learning (Cook, 2012; Eraut, 2000; Eraut, 2007a).

One approach, which has recently been adopted within the field of medical education research, is the use of Foucauldian theory and perspectives. The Wilson Centre, led by Brian Hodges, have been particular champions of the use of Foucauldian Discourse

Analysis methods in recent years, and certainly influenced my own interest and enthusiasm to use this method for this thesis. Hodges has brought many sociological, philosophical and historical perspectives to the attention of medical education researchers, encouraging use of a reflexive, critical lens in order to situate their research within a particular theoretical perspective. He emphasises the importance of presenting research findings as historically specific and culturally contingent, rather than transcendent and universal 'truths' (Hodges, 2005, p. 613). He also highlights the possibilities for simultaneous existence of discourses or 'truths', their prominence or dominance varying over and across time and contexts. He describes discourses as:

> *'...not simply autochthonous entities that emerge like shooting stars from a dark night. Discourses emerge because there are important sociological, political, economic and cultural contingencies that make them possible. Discourses are associated with power. The dominance of one discourse over another has significant implications for what is considered legitimate, what positions are made available for individuals, what will get published, what will be funded and what institutions will gain power and influence." (Hodges, 2007, p. 696)*

In 2013, the Wilson centre produced an AMEE (international association for medical education) 'guide' to the use of Foucauldian Discourse Analysis in medical education (Kuper, 2013b), and more recently in article form for *Medical Education* (Hodges, 2014). Both these draw upon Parker's analytic framework (Parker, 2002) (see Appendix 5). There is a subtle distinction between the way in which 'discourse' is conceptualised in Parker's framework and the work I have drawn upon by Andersen and Howarth (Andersen, 2003; Howarth, 2000). Whereas Parker treats 'discourse' as a specific object of analysis, Andersen and Howarth treat 'discursive practices' as the object of analysis. This distinction is small and reflects a spectrum of approaches within poststructuralist research ranging from concern about societal discourse to specific texts and micro-analysis of conversations (Burman, 1993). Here, however, it could lead to the production of different research questions and results. For example, the first asking '*what* discourses are present in the text(s)?', producing a set of identified 'discourses'. The second asking '*how* are discursive practices constructed in the text(s)?', producing a picture about how particular discursive practices have been constructed.

To my knowledge, no-one has as yet used Andersen or Howarth's work specifically in medical education research, making this thesis an original contribution to the literature.

Parker's framework has been used by researchers in both primary care and medical education. Shaw and Greenhalgh, for example, used this framework within the context of primary care to analyse both policy documents and interview data from stakeholders. They justify this approach as a means to explore how social problems and solutions are created in discourse, highlighting the situated nature of knowledge, language and discourse in the production of policy (Shaw, 2009; Shaw, 2008, p. 2508).

Whitehead et al., from the Wilson Centre, have used Parker's framework in two relevant medical education studies. The first examines the nature of knowledge in medical education curricula. She examines the tension between scientist-doctor – advocated by Flexner as 'an incisive thinker [who] would draw upon multiple forms of knowledge, including the natural sciences, social sciences and humanities' and the treatment of science as an 'object within the curriculum' (Whitehead, 2013, pp. 28-29). She highlights the recurrence (and therefore unproductive nature) of post-Flexner undergraduate medical curricula reforms which position science as 'curricular content', subsequently problematising the incorporation of vast and expanding quantities of 'science knowledge' into medical curricula, rather than bio-medical science being understood as only one of a number of relevant forms of knowledge (Whitehead, 2013, p. 29). Whitehead is, at the time of writing, head of The Wilson Centre.

Whitehead and Kuper use this idea of the 'biomedical feedlot' (Whitehead, 2012) in their analysis to argue for a greater historical awareness of the repetition of debates around curricular content and 'overload' which they position as marginalising opportunities for other knowledge forms, such as humanities and social sciences, being legitimately and more substantially included in medical curricula. Whitehead concludes that by framing science as curricular content and a curricular object ('set of facts'), rather than a 'way of thinking', biomedical science repeatedly becomes prioritised above other forms of knowledge which might also be considered for inclusion in the curriculum (Whitehead, 2013, p. 31). This thesis is not looking at the entire curriculum, nor curriculum documents, but there are parallels within the examination of the treatment of knowledge in these research texts and claims about its specificity in relation to other knowledge forms.

Whitehead et al. also published an analysis of curricula documents from Canada and the Netherlands, tracing the appearance and absence of 'the person' within competency-based curricula (Whitehead, 2014). By using the critical lens of FDA to examine competency-based curricula, the authors make explicit the historically and culturally situated nature of these competency curricula, challenging the common perception that they are 'objective' and

value-free (Park, 2014b). This paper raises some challenging questions about the inclusion of 'the person' in curricula as an intrinsically good thing. Is it, for example, actually constructive to include 'person-ness' in competency-based curricula documents, and how might students be called forth by the text as 'a person', or not accepted as such (Park, 2014b)? The opportunities and challenges of positioning personal and interactional knowledge within a curriculum are relevant to this thesis in relation to the ways in which certain knowledge forms are specified within the research texts as taught and learnt in general practice placements (e.g. communication knowledge) and how this produces particular subject positions for patients, students and GPs.

Summary

In summary, there is a substantial published research literature about general practice placements which I use in this thesis as my 'data'. Critical questions about the power relations shaping ways in which what is taught and learnt in medical education placements are determined have been identified within the literature - see for example (Bleakley, 2009, p. 299) and (Brosnan, 2009a). Foucauldian discourse analysis has been pioneered within the field of medical education research, particularly by The Wilson Centre clinicians / academics. Approaches to using FDA vary and those used, to date, in primary care and medical education research have tended to focus on an approach outlined in Parker's Framework. Again, no-one to date has published research in this field which uses FDA in the field of research about general practice placements, nor in particular the approaches outlined by Howarth and Andersen (Andersen, 2003; Howarth, 2000).

Method

In this next section, I outline my method: how I have operationalised my analysis.

Research Question:

This thesis examines how the published research texts about undergraduate medical education in the UK general practice setting construct knowledge. To do this, I have two research questions:

- What is said to be taught and learnt in general practice placements?; and
- How is the production of research justified?

These questions helped me to identify what is claimed as the specificity of general practice placements in contrast to other forms of medical knowledge; and what is claimed as the specificity of the subjects of research texts about general practice placements. The second research question enabled me to examine how the existence and production of research is legitimised or claimed in this discursive field. I was then able to examine the strategic relations between these two elements and the discursive field of research texts about general practice placements as a whole.

Identifying the texts

In order to identify texts from which to select for analysis, I enlisted the support of a medical and educational librarian to search seven electronic databases (Medline, Embase, CINAHL, PsycInfo, BEI, ERIC, AEI) to March 2013. I used search terms relating to medical education, general practice and family medicine (see Appendix 1 for an example of the Medline search strategy).

A paper was considered relevant if it was about:

- Medical students i.e. students undertaking a course of study at a medical school in order to reach a primary qualification in medicine, enabling them to practise as doctors
- Learning within the UK
- Learning within the general practice setting (e.g. not a university classroom, hospital or community out-patient clinic)
- A primary (empirical) research paper published in an academic journal
- Text written in English

I applied an English language filter to exclude studies that were not written in the English language as I did not have the resources to translate these. I also felt that the in-depth analysis of texts for this thesis would prove particularly complex if using a translation from a second language. Studies conducted outside the UK were excluded. This meant that I specifically excluded other countries from the searches in the search strategy, but ensured that UK-based studies published in, for example, US journals were not lost in the searches. During selection of papers, where it was not explicitly stated where the study was conducted, the location of the authors was considered. If all authors were based outside of the UK, the paper was excluded. I tested the sensitivity of this strategy to identify relevant studies using a review conducted by Tim Dornan et al. about early community placements

(which included a number of general practice placement research studies) that were based in the UK (Dornan, 2006).

The term ‘general practice’ is quite consistently used within the UK literature. However, some authors use the terms ‘community’, ‘family medicine’, ‘ambulatory care’ or ‘primary care’ interchangeably when referring to general practice placements. Identification of texts for this thesis therefore required careful examination to clarify their relevance. There are often subtle distinctions between these terms. The term ‘general practice’ is often used to describe one element of primary care. ‘Primary care’ is a term used internationally to describe care in the community setting (accessible to patients locally) providing a universal service (direct access to all patients) and comprehensive care (a patient can take any problem) (Alma-Ata, 1978; WHO, 2008). The terms ‘family medicine’ and ‘ambulatory care’ are mainly used within international journals to mean general practice, or community-based care respectively.

The definition of a research paper was kept broad in order to maximise the variety of available papers. Similarly, I did not wish to impose ‘quality criteria’, nor limit my selection to particular methodologies, as part of my analysis was to explore how the production of research was justified. I therefore included a text if it had a ‘method’ (however brief) and contained primary data. Studies with no new primary data (e.g. systematic reviews) were excluded, but used as a source of identifying other studies.

Sampling

The purpose of this analysis was to make visible instances of particular phenomena within texts, producing a critical lens with which to view further texts or work. Many systematic reviews aim to address questions about effectiveness of an intervention. Importance is, therefore, attributed to publication and selection bias, and the use of a reproducible process to *comprehensively* identify *all* relevant literature within a particular set of criteria (e.g. time of publication, topic, participants etc.), in order to make generalisable claims. For this analysis, however, I have selected texts using theoretically informed, iterative, critical case selection (Brown, 2010, p. 28) based on my interpretations and understanding of contrasting cases. Parker describes this process as selecting some initial texts, considering what they represent and how they are situated within a more expansive web of documents, thereby shaping the production of a final set of documents within a particular timeframe (Parker, 2002). Brian Hodges’ group describe this process of text selection for FDA and the close link between the research question and text in determining questions of relevance:

> *"Once the general category of texts that are relevant to a research question has been identified, the researcher then selects specific texts according to his or her particular methodological approach. Some methodologies require a more rigid, predetermined delimitation of the texts to be studied, whereas others are more fluid or eclectic in their collection of textual data, but all require setting some sorts of boundaries around the texts to be studied." (Kuper, 2013b, p. e855)*

The emphasis here is not upon inclusion of ALL relevant texts, but instances. Nor is there an expectation that the researcher will identify all relevant texts from the outset, more that analysis facilitates iterative exploration and identification of further potentially relevant texts:

> *"Unlike some other forms of text analysis, a Foucauldian approach requires bi-directionality. That is, a researcher does not just choose her set of texts and move from text to discourse. Instead, there is a process of back and forth between text and discourse." (Kuper, 2013b, p. 857)*

For this thesis, I had gathered a collection of published research texts about a particular topic. I did not know from the outset which papers and sections of papers might ultimately be included in my collection of statements or 'archive'. I began by selecting some contrasting texts, some from different publication periods, and some 'at random'. This sampling process was not designed towards claims of generalisability. There are, therefore, limitations, as with any method, to the way in which the research products of this thesis can be claimed to represent the whole archive. These texts were selected because they were about general practice placements. I have not, however, included texts researching teaching in other settings to explore the presence or absence in these texts of reference to general practice placements.

Through repeated readings and familiarisation with the available published research, I began to construct a set of documents or 'archive', which provided different rules of regulation of the discursive practices about general practice placements in this field. This process involved close reading and line-by-line analysis of a number of papers to begin to identify particular ways in which the texts produced general practice placements as object, subjects, concepts and strategies. I then began to search specifically for examples that supported or refuted these (continuities and discontinuities) over the timespan of the archive. I periodically reflected on the papers included in my archive, and addressed any apparent imbalances in the type of journal, methodological approach, or time period I was examining (see Appendix

4 for an example table sampling the breadth of journal types and genealogical range). I began by examining the range of ways in which general practice placements as an 'object' were characterised. I then began to build up my examination of the subject positions these characterisations made available, and the conceptual logics and strategies governing this discursive field. Where dissonance arose, I did not attempt to combine or ignore, rather to use this as a critical question to further develop my analytical categories.

I found the selection of texts for this thesis quite problematic at times, experiencing anxieties about the representation in my analysis of the archive as a whole. I did not have a clear plan from the outset about which texts I was planning to include, rather I began somewhere and then drew upon other texts both to generate new ideas and address or refute particular emerging aspects of analysis. I fluctuated between using my 'insider' familiarity with much of the content of the published research texts to identify particular aspects of papers, while also using a critical perspective to make the familiar strange and avoid reinforcing any particular assumptions I might have about particular authors, journals or texts. I am reassured, therefore, that the analysis produced many insights, which I had not previously anticipated.

Doing FDA

In this section, I set out each of the analytical categories used in my analysis. There are many ways in which the process of FDA can be understood and done. I hope that this section will make explicit how I have understood and conducted this analysis. I have drawn, in particular, on the work of Andersen and Howarth in categorising my data as described in the sections below (Andersen, 2003; Howarth, 2000). I was aware throughout this process that through writing, I was not only analysing the discursive practices of others, but also producing my own through construction of this thesis.

What are statements?

The units of analysis for FDA are 'statements'. These might comprise, for example, texts, diagrams or grids. This process of FDA has produced something called a *discursive practice* or *discursive field*. This is an analytical product achieved through examining the established *rules of formation* or 'systems of dispersion' within a set of statements (Howarth, 2000, p. 52). Andersen emphasises that the discursive practice for Foucault is not something *illuminated* by analysis, but *produced* by analysis. For Foucault discourse is not *behind* language, but *is* language. The process of FDA is analysing *how* language operates, examining, for example, how a statement produces, constructs or identifies the object about which it speaks (Andersen, 2003, p. 11).

The categorisation of text as a 'statement' is an iterative process (Andersen, 2003, p. 13). Defining what 'is' and 'is not' a statement worthy of inclusion is a challenging, iterative and ultimately interpretative process, involving the identification and compilation of statements in 'their historical dispersion and... specific momentary value' (Foucault, 1968a). This involves constant movement between defining what is a statement to analyse; analysing the statement; then determining what other texts might contain suitable statements to include (Andersen, 2003, p. 13). While statements are united by their position within a '*field of discursivity*' (here, my analysis of published research texts about general practice undergraduate medical education), this field is likely to comprise a system of heterogeneous statements without a unified or underlying coherence (Howarth, 2000, p. 51).

Discursive formations

FDA is a theoretical lens for categorising and analysing texts in a particular way. Within 'The Archaeology of Knowledge' (Foucault, 1974), Foucault describes discursive categories (objects, subject positions, concepts and strategies) as elements of statements and ways in which the *relationship* between statements can be explored (Foucault, 1974, p. 34). Throughout this analytical process, the emphasis is not upon the question 'what' or 'why', but 'how'. Foucault seeks to account for the creation of discursive categories by relating them to the rules governing their formation (Howarth, 2000, p. 52). The focus of analysis is upon 'the rules' that govern the production of statements, and the way they structure the formation of objects, ways of speaking, concepts and strategies (Howarth, 2000, p. 52). This identifies the rules of formation ('discursive formations') which determine production of discursive practices and particular systems of knowledge (Howarth, 2000, pp. 51-52). Discourses, unlike rules of grammar, are 'made up of a limited number of statements for which a group of conditions of existence can be defined' (Foucault, 1974, p. 117). These statements are the products of discursive practices, governed by historically and contextually contingent rules of formation, not necessarily explicit to the practitioners enunciating them (Howarth, 2000, p. 51). Foucault distinguishes between four levels of discursive formation or 'bodies of rules' for the formation of statements (Foucault, 1986, pp. 21-71). These are the formation of objects; subjects; concepts; and strategies (Andersen, 2003, pp. 14-16). This is a way of conceptualising what data comprise. Through categorising particular aspects of statements as object, subject and so on, the analytical process produces 'data'.

The selection of particular statements for analytical attention in this thesis was guided by a set of critical questions for each category from Andersen (Andersen, 2003, pp. 14-16).

These critical questions included for objects: how do statements construct, order and classify objects (here general practice placements); and how are objects specified and characterised? For subject positions: what are the available subject positions; what qualities are associated with particular subject positions; how can subject positions be taken up or used? For conceptual categories: how do concepts organise and connect statements; how does a statement actualise a particular concept and not another; how do discursive formations (rules governing a set of connected statements) draw on concepts from other formations? The aim of the analytical categorisation was, not only to identify concepts, but also to identify the links or dispersion of concepts within the texts. Questions while reading the texts therefore included: What are the rules for placing statements inside or outside a discursive practice? For example, how are statements taken as acceptable or truthful in a discursive practice; how are statements from other discursive practices invoked favourably (for example through analogy, general principles, models or higher authorities); and how are statements, which are no longer accepted, used to make a distinction with others? Finally, for strategies, asking: what kind of strategy is realised when discursive formations emerge; how do formations constitute each other; and what relations and parallels does a discursive formation have with other formations?

My critical analysis and ways of responding to these questions were shaped by my reading multiple texts by Foucault and becoming immersed in his particular perspectives, but were no doubt also influenced by other sociological and philosophical texts I have read and my own professional experiences. What I ‘saw’ in a text, might have differed had I been analysing for a different purpose, or differed to what another researcher might have seen and therefore selected for analytical attention. This process involved asking about the treatment of particular discursive categories within the text. Examination of the treatment of instances of categories was guided both by the research questions and iterative analysis. This was not a process of searching for *meaning* behind the texts, but looking within the statements at how, for example an object, was constructed.

I found this process challenging in a number of ways. Often, asking these different questions of the text required multiple and repeated readings. What I found particularly challenging was separating out my analysis of particular statements to fit with a particular category. I might, for example, find a sentence or paragraph which contained some rich instances not only of how the statement constructed general practice placement knowledge as an object, but also how a particular subject position was made available and what this enabled the subject to do or say. As my analysis developed, I therefore shifted the focus of the writing

from particular extracts, towards emergent analytical categories, facilitating my focusing analytical explanations on one particular discursive formation category and its treatment within the text. At times within my analysis, I therefore had a particular quote more than once, with contrasting analytical lenses.

Similarly, the layers of analysis for object, concept and strategy were often inter-related, ranging from more micro to macro levels of interpretation. I had to make these distinct within my analysis, in order to relate instances within each category before I could examine these discursive formations in relation to one another. One early iteration of my thesis, for example, had chapters headed 'object', 'subject positions' and so on. The process of analysis, then, focused first upon the statements and iteratively determining what emerged within particular discursive formations in that statement. The second part of analysis and writing involved focusing on emergent analytical categories, placing together ideas and arguments that had emerged from the texts, and beginning to examine how particular power relations were produced within the texts.

It is important to mention here that although Foucault, and other researchers after him, have developed some questions relevant to each discursive formation category, there are no 'rules' governing what components of a statement within a particular context might be classified as one or other category. As Foucault reflects:

> *"But it turned out that the difficult point of the analysis, and the one that demanded greatest attention, was not the same in each case."*
> *(Foucault, 1986, p. 72)*

There are ambiguities in 'applying' this process of categorisation and production of data, to a particular set of texts or context. I, for example, debated the categorisation in this thesis of 'communication' and 'attitudes'. I experimented both with categorising these as instances of the object of general practice placements and also as concepts. It wasn't until I began to use the idea of gazes to organise the contrasting elements of my analysis, that their position became clearer to me: whether they were treated as an isolated compartment, or integrated aspect of placement teaching. Within the categorisation of subject positions, my analysis began by attending to the particular social groups of student, GP, patient and researcher. This enabled me then to define a range of subject positions produced within the texts and highlight their distribution to particular social groups dependent upon the ways in which placements had been characterised and research justified. These emergent categories of

subject positions (such as ‘intruder’) might, then, be present within other discursive practices, but be distributed to different social groups.

A further analytical ambiguity arose when trying to categorise the two contrasting ways in which the object of general practice placements (and related subject positions and concepts) were characterised. My analysis produced two differing sets of meta-rules, or strategies. I chose to draw upon a technique used by Foucault in ‘Birth of the Clinic’, and name these two dissonant analytical ways of characterising placements as ‘gazes’. One, a ‘gaze of discovery’ positions what is taught and learnt in general practice placements as workplace-based learning, and the other ‘gaze of deciphering’ as pre-determined or curricula compartments. This terminology not only emphasises how these are contrasting ‘ways of seeing’ general practice placements, but also makes explicit a connection between my analytical findings and those included in ‘Birth of the Clinic’ regarding the integration or separation of clinical service and teaching. I then named the over-arching strategies underpinning the contrasting characterisations and justifications of research, as strategy categories, such as the treatment of placements as ‘supplementary’ and ‘different’ and justification of research as ‘evidence-based’ and ‘evaluation’.

The object

In this thesis, the process of FDA involved categorising instances of ‘the object’ general practice placements within these texts. When reading the texts, I was constantly asking *how* general practice placements were characterised. This process produced a number of examples of ways in which placements were treated – these included ‘disease’ and ‘communication’ knowledge. The texts positioned particular knowledge forms as being available to be learnt or taught within the general practice space or placement. As part of this analysis, I was also asking what was not treated as a legitimate general practice placement, or what was missing. This helped to identify examples of distinctions made within the texts between what was available to know in general practice in contrast to various other settings, such as the hospital or university. I had not selected texts about other learning settings, or the general practice setting solely as a work-place (rather than teaching setting for medical students), but distinctions did emerge within the selected texts, either through comparisons with, for example, hospital teaching, or through treatment within the texts of different general practice placements, as one type of object and not another.

The purpose of this analysis was not to provide a coherent and unified definition for general practice placements, rather to demonstrate the variety of ways in which it has been treated:

"...statements different in form, and dispersed in time, form a group if they refer to one and the same object.... But I soon realised that the unity of the object does not enable one to individualise a group of statements, and to establish between them a relation that is both constant and describable.... this group of statements is far from referring to a single object, formed once and for all, and to preserving it indefinitely as its horizon of inexhaustible ideality."
(Foucault, 1974, p. 35)

This analysis is looking at the *range* of ways in which an object (here general practice placements) has been characterised – both across texts and over time. A group of statements can be unified by their reference to a particular object, but an object can be constituted differently by those statements that name it and is not a single object existing uniformly through time and space. The process of FDA questions *how* a statement constructs its object and how rules govern the appearance and transformation of those objects.

The concept

In analysing the formation of concepts, Foucault focuses on the logical relations between statements, such as rules of inference; rules which define whether classes of statements are to be accepted (or not); and rules governing ways or techniques in which certain operations can be applied to statements to produce new statements (Howarth, 2000, p. 53). Foucault explores how these are formed within a discursive practice, rather than understanding concepts to be the result of a gradual accumulation of empirical knowledge, which is somehow mapped onto an external reality (Howarth, 2000, p. 54). The status of a concept and its inclusion or exclusion within the discursive practice may change over time (a 'discontinuity'), or remain continuous (as is predominantly the case for concepts within this thesis). In any instance, the statement may refer to a concept explicitly or implicitly by, for example, repeating, modifying, adapting, opposing or commenting on a concept (Andersen, 2003, p. 11).

The categorisation of concepts within this analysis is an interpretative step to identify the various 'logics' used to construct an object within the text. This looks at the logic that makes possible the existence of an object within a statement, as well as the links or dispersion of concepts and ways in which concepts relate to those within other discursive formations. In this thesis, for example, I identified 'innovation' as a concept. While few texts referred explicitly to general practice placements as 'innovation' (although some did), the texts used

a number of ways to treat this knowledge as new and different, leading me to name and categorise this treatment as a logic of innovation. I then explore how this logic relates to a second logic of GMC policy, both to support the existence of placements, but also position and re-position placements and teaching methods used in placements, as innovative.

Subject Positions

A discursive practice will not only determine how the object is treated, but also how particular subject positions are made available. Unlike many humanistic accounts of discourse, Foucault does not position the subject as the founder of a discursive practice, rather the subject is positioned *by* the discursive practice and subsequently particular ways of being and speaking made available (Howarth, 2000, p. 50). This analysis treats the subject as a product of a discursive enactment, rather than a reflection of social relations that operate independently to it. The nature and distribution of the subject position is then situated and dependent upon the discursive practice (Foucault, 1974, p. 183). This understanding of the subject is very different to many other sociological ways of conceptualising identity or roles, and their relationship with their context (Butler, 1999). This places analytical emphasis upon how the subject is realised textually, rather than exploration of meaning beyond or 'behind' the text.

Within his analysis of 'the subject', Foucault draws a distinction between 'subjection' and 'subjectivation'. By subjection, he refers to the way in which a subject is identified and given a place within a discursive practice - a related term is *interpellation* (Althusser, 2008; Zizek, 2012). It is from this place or position that a person speaks and acts intelligibly (Andersen, 2003, pp. 1-32). The notion of subjection describes how particular ways of making meaning are imposed on subjects, exercising power by constraining the capacity to be heard, to speak and be understood. Whereas Foucault's early work focuses on 'technologies of power' (*external* mechanisms that produce and regulate subjects), his later work refers to 'technologies of self': *internal* mechanisms of power whereby a subject complies with social norms, through self-discipline and self-surveillance, so as to be intelligible to him or herself and to others as a 'good person' (Foucault, 1980b; Schirato, 2012). A particular discursive practice, then, will make particular subject positions available. The way in which those subject positions are taken up by individuals is described by Foucault as 'subjectivation' (Andersen, 2003). Here, the subject becomes actively attached to a given subject position; these are not so much imposed as wanted and adopted, as conditions for being recognised and intelligible within that discursive practice. Subjectivation, then, points to the way in which

a subject is not only made (or named), but also given 'internal' wishes and desires (Schmidt, 1990).

Within this thesis, I have analysed texts. My analysis identifies how treatment of general practice placements in particular ways, makes available specific subject positions. I then examine how these subject positions are characterised and distributed between different social groups (such as GP, patient and student). What I have not examined within this thesis are processes of subjectivation – ways in which individuals actively take up or adopt (or not) these available subject positions to shape an individual's sense of desired direction and development (Park, 2014b).

As part of my development of subject position categories, I examine from which subject positions the objects appear the way they do in the text (Andersen, 2003, p. 15). These positions include, for example, subjects who communicate; have attitudes; provide a service; or even disrupt a service. The analysis then examines *how* these available subject positions are characterised and distributed between different social groups. How, for example, students are positioned as subjects who disrupt a service, being treated as an intruder to the GP-patient interaction within routine clinical appointments, through a gaze of discovery. I also examine how treating general practice placements as either service-based knowledge or a pre-defined curricular compartment of knowledge, makes available different subject positions for patients as, for example, 'subjects with disease', or 'educators' in teaching encounters. This distinction also shapes the availability for the GP as subject who teaches and/or subject who provides a service. Further, this distinction also determines within the texts whether students take up the subject position of subject who learns the curriculum, or subject who learns to provide a service.

The strategy

Chapter 6 examines strategies within these texts. This category is a further interpretative step in the analysis and, for me, included attention to the power relations produced within the texts. Categorisation of a strategy involves identifying the overall (or 'meta') set of rules within a discursive practice, governing selection and acceptability of particular ways of positioning objects, subjects and concepts (Andersen, 2003, p. 15). There are, within any discursive practice, a range of available 'operational possibilities' (Foucault, 1968b). Within a particular context, however, only certain choices will be acceptable (or not) within the rules of production for that particular discursive practice. The way in which an object is constituted and subjectivities established are governed by the boundaries of a strategy in a particular

discursive practice. These possibilities may not necessarily be unique to that particular context, but characteristic of broader social processes. FDA may, therefore, identify ways in which strategies are, in fact, inter-discursive or negotiating boundaries.

A strategy might also be thought of as a theme or theoretical lens (Foucault, 1986, p. 71). Foucault refers, for example, to the 'development of the Marxian theory of value within the discourse of modern political economy', rather than the 'meeting of Marx and Engel' and individual 'genius of great men' (Howarth, 2000, p. 54). My analysis attempts to examine how strategies are used. A strategy may only become apparent through the process of analysis and is not necessarily an explicit or conscious 'choice' during production of the texts. Howarth reminds us that strategies are not necessarily coherent or consistent – they may, in fact, be 'points of diffraction', where two dissonant, incompatible or contradictory statements are tolerated (Howarth, 2000, p. 54). Either way, only a certain number of theories or strategies can be made available or tolerated within a particular discursive practice. Within this thesis, for example, I examine the tension between the texts attempting to promote the object of general practice placements, whilst also adhering to a strategy positioning these placements as supplementary or different. Later, I discuss the implications of such a strategy and how it produces particular power relations within the texts, which marginalise general practice placements in relation to other knowledge forms.

Justifications of research

My second research question asked how research is justified, in order to understand how particular ways of justifying research relate to ways in which general practice placements are characterised. I therefore examined how a text made claims about the rationale or significance of the research, perhaps as a solution to a particular problem. I also examined how ways of doing research were made thinkable (or not) and how this produced particular available subject positions for the researcher. This highlighted, for example, how a dominant way of justifying research is evaluation. This produces a particular subject position for the researcher as 'evaluator', legitimating particular ways of treating research and teaching practice in the texts. This way of justifying research then aligns well with specific ways of characterising placements as pre-defined components. Placements then become more commonly characterised or thinkable in particular ways within this field, dependent upon which ways of justifying research are made legitimate.

Foucault argued that an author's production of knowledge can be 'the truth', but simultaneously not 'within the true' of a particular discourse (Foucault, 1981, p. 60). There

may be many ways in which production of research can be justified, but only some treated as legitimate within a particular discursive practice (Howarth, 2000, p. 57). Similarly, a researcher's position in relation to production of research can be reified or the legitimacy of their position and knowledge production increased through their adhering to the rules within a particular discursive practice. According to Foucault, this produces tireless repetition within texts in the belief that 'behind them there is a secret or a treasure', producing a legitimate, unified account of the author position, while also claiming to be unearthing something new and valuable in each recounting (Foucault, 1981, pp. 56-57). This analysis does not attempt to impose assessment of claims to legitimacy (were these claims 'right' or 'wrong'), as these judgements vary depending upon the discursive lens through which they are constructed. It does, however, attempt to examine *how* the production of research is justified and the subject position of the 'subject who produces research' constructed.

Ethics

This project did not require formal ethical approval (see Appendix 3). There were, however, a number of ethical considerations within this research process. The 'data' for this thesis were all available as published texts through academic libraries. Whiteman writes about the ethical dilemmas in 'researching' on-line communities and the challenges of a dual role as both researcher and community participant (Whiteman, 2012). While I hope that this thesis will overall make a positive contribution to the community of undergraduate general practice medical education, I also feel that I have in some way betrayed the community through using these texts for a purpose which the authors did not intend – the texts themselves becoming an object of research. My analysis did not focus upon the social practices behind the texts, but the texts themselves – I did not, therefore, include interviews or a space for author's responses to my analysis within the thesis. Many of the authors are friends and colleagues. I have used the analysis to illuminate how the texts contribute to a discursive practice. Others might produce different ways of understanding the 'treatment' of categories within the texts. Many authors would refute explicit participation in particular discursive practices – it is however part of the purpose of this analysis to make visible and make curious this participation:

> *"We use this appearance of truth to determine how we live our lives, policing ourselves within discursive boundaries. By exploring the power of discourses in determining social action, we can make space for resistance and change."*
> *(Johnston, 2014, p. 554)*

My thesis is not only analysing the statements and discursive practices of others, but also producing my own discursive practice through writing for this thesis. I have written within Chapter 7 about how I am positioned within this thesis as insider or outsider researcher. While I may not claim to have a unified or coherent way of participating in or contributing to the discursive practices discussed in this thesis, Foucault's writing has encouraged me to consider the 'truths' I encounter and produce as a professional and researcher.

Chapter 3: Gaze of Discovery

Introduction

In the next two chapters, I produce a map or topography of the range of ways in which general practice placements (the 'object') are characterised within the discursive field of research texts. During my analysis, I encountered a tension in the characterisation of placements. There was not one unified coherent way in which placements were characterised across the texts. There were, instead, two contrasting ways in which placements were characterised co-existing within this discursive field. The two are not necessarily mutually exclusive, but at their polar extremes, these characterisations produce contrasting concepts about what 'good' teaching and learning during a placement might be, and produce different available subject positions.

It was not clear to me from the outset how best to categorise and present my analysis. I tried several different ways of writing about my analysis, trying to accommodate these tensions in the characterisation of placements. I then went back to reading 'Birth of the Clinic'. In one section of the book, Foucault writes about the development of the relationship between the clinical workplace and delivery of medical education. Foucault charts the historical shift of teaching from 'the clinic' – a separate dedicated teaching space with invited patients, selected specifically for the purpose of teaching to allow students to 'decipher' relevant diagnoses - to an apprenticeship or 'gaze of discovery' within the hospital, where experienced professionals and naïve students' discoveries with the patient are contemporaneous:

> *"…unlike the eighteenth-century clinic, it is not a question of an encounter, after the event, of a previously formed experience and an ignorance to be dissipated. It is a question, in the absence of any previous structure, of a domain in which truth teaches itself, and, in exactly the same way, offers itself to the gaze of both the experienced observer and the naïve apprentice: for both, there is only one language: the hospital, in which the series of patients examined is itself a school." (Foucault, 1973, p. 82).*

A distinction is made here between a system of teaching and learning in which a doctor's clinical experience with the patient is separated from the student's experience, treating student learning as a remedy of 'ignorance', attempting to decipher pre-determined

knowledge, contrasted with a system in which the student *participates* in the patient-based experience, offering an opportunity for contemporaneous discovery of 'truth'. I found this distinction helpful in making sense of the contrasting ways in which general practice placements are characterised within the texts. I choose, therefore, in this chapter, to examine how general practice placements are characterised in one way as learning defined in practice during teaching, which I have called a 'gaze of discovery'. In the next chapter, I examine how placements are characterised as knowledge that is pre-defined by the university or curricular structure, which I have called a 'gaze of deciphering'. In Chapter 6, I examine the strategies produced, some of which are coherent across these characterisations and others of which are dissonant.

The production of this map became increasingly fascinating for me when I began to consider the available subject positions produced when characterising placements in different ways. Within the constraints of this thesis, I have sometimes embedded discussion of available subject positions in sections about how placements as an object are characterised, or the conceptual treatment of placements. At other times, I have written distinct sections about a particular subject position. My analysis examined how particular subject positions are produced for individuals within this discursive space, and the rules by which subjects are accorded the right to speak from a particular position (Howarth, 2000, p. 53).

Foucault argues that social subjects do not autonomously produce discourses, but are the *function* and *effect* of discourse (Foucault, 1974, pp. 95-96). This analysis, then, explores 'what is' and 'what is not' a subject position within the discursive practice(s) in the examined texts. These are not exhaustive, but produced in relation to the purpose of this thesis and the characterisation of general practice placements. This shows us how particular ways of making meaning are imposed by a discursive practice on subjects – how the capacity to be heard and understood, and to speak, is constrained or restricted in particular ways. Foucault refers to 'technologies of self' as internal mechanisms of power whereby a subject complies with social norms of a particular discursive practice, so as to be intelligible to both himself and others as a 'good' or particular person (Foucault, 1980b; Schirato, 2012). This thesis does not examine how subject positions within the texts are 'taken up' by individuals, but maps the different subject positions or discursive spaces, made available within the texts, from which something can be said (Andersen, 2003, p. 11).

This chapter focuses upon how general practice placements are characterised conceptually as workplace-based learning, providing learning in conjunction with clinical service as a

student apprenticeship. Knowledge is treated as produced in the workplace, rather than pre-determined by a curriculum, hospital or university. Particular forms of knowledge become valuable or legitimate through this lens, including interaction with patients; experience; and balancing or negotiation of multiple priorities relevant to professional general practice. Particular subject positions are produced for patients as subject with contextualised disease and subject who educates. Students are offered positions as participatory learner and sometimes intruder or disruptor of service. The GP is offered a position as facilitator of learning and integrated teacher-clinician. I will now examine each of these elements.

Patient-based interaction

One way in which the object of general practice placements is characterised within a gaze of discovery is as patient-based interaction. A distinction is commonly made between general practice placements and hospital placements, characterising general practice learning as involving interaction with patients. Texts use terms such as 'patient-based learning' and 'patient-centred learning' to refer to student interaction with patients during general practice placements. Processes such as 'history-taking' and 'examination of patients' are said to be taught, students exchanging knowledge with patients through touch and talk. In contrast, hospital-based placements are often said to involve management of disease, and exchange of knowledge between students and clinicians or faculty. Here, for example, is a text from the CeMENT study which contrasts how learning is achieved in general practice and hospital settings:

> *"... whilst on general practice attachments, they **presented more histories and were observed examining more patients** than in hospital..... The hospital attachments were more useful for helping students **learn to write competent clerkings** and **progress notes** and for **studying disease management**. "*
> *(Murray, 1999, p. 175)*

Both the general practice and hospital placements in this study aimed to teach the same topics. Student feedback reported in the texts, however, characterises general practice placements as providing patient-based elements of learning, whereas hospital placements are said to focus on knowledge about disease, and communication with colleagues through the written word. Student interaction and exchange of knowledge with patients is located in general practice placements, and in contrast, student interaction and exchange of knowledge with professional colleagues in the hospital. This is evident in the next example, again from the CeMENT study, but this time in the form of a quote from a student participant:

*"...[in the community] you definitively get to see the patients more as **proper people rather than just lying in a bed**... you have a **better insight into what causes health problems** ... you **get to know the person** better which has a huge impact on a person's health generally and his response to treatment... a more realistic attitude.... in a **hospital you're sheltered from the outside world** in your **citadel with other doctors**." (O'Sullivan, 2000, p. 654)*

Hospital placements are said to focus on interaction with professional colleagues, and separate the patient from their context. In contrast, general practice placements are said to promote interaction between the students and patients, making visible contextual knowledge about the patient's health; contributory factors to ill-health; and factors which might shape the patient's response to treatment. General practice placements are said to make visible the patient as socially distributed and 'real', rather than an isolated and de-personalised bed occupant. The inter-connected nature of general practice learning is said to produce a more 'realistic [student] attitude', shaping students' expectations about how a disease might progress and respond to treatment as context-dependent.

In summary, general practice placements are often characterised, in contrast to hospital placements, as patient-based interaction, providing teaching through talk and touch with patients (such as history and examination practice). Whereas hospital placements are characterised as learning about interaction with colleagues through the written and spoken word, general practice placements are characterised as learning through interaction with patients.

Experiential knowledge

Related to the characterisation of general practice placements as involving interaction, placements are also characterised as experiential learning. This includes both attention to the patients' experiential knowledge of illness (and health), but also attention to the students' experiential learning. Patient concerns, for example, about their ill-health, or stories about their operationalisation of treatment, are positioned within this gaze as a legitimate aspect of knowledge to be learnt during general practice placements. General practice placements are characterised as a place where legitimation of experiential knowledge can be both observed and rehearsed. Here, for example, is a text taken from an RCGP funded study using focus groups and interviews to compare students' experiences of patient-centred consultations (both observation and participation) in hospital and general practice settings:

*"The concept of adopting a **patient-centred approach** in clinical care was **unfamiliar to students**. Not only had the idea not been introduced during formal teaching but also its observed practice on the wards was the **exception rather than the rule**....There [was] a lack of encouragement [in ward-based teaching] to **delve into a patient's social history** which may have a **bearing on the patient's problems and subsequent outcome**... the community placement was praised as **having encouraged students to recognise the relevance of addressing patient concerns** as well as the **opportunity to 'practise'** this in an environment in which they felt comfortable." (Thistlethwaite, 1999, pp. 683-4)*

The legitimation of patient experiential knowledge broadens the students' focus from standardised or text-book categorisation of disease, to more variable issues of how a disease, or symptoms, affect a particular person at a particular time. This characterisation of knowledge to be learnt legitimates students' exploration of patient experiences, and also learning of communication processes to enable discussion of this knowledge between student and patient. This legitimation of experiential knowledge also positions student experience during placements as a valuable feature of teaching, prioritising, for example, student rehearsal of history and examination practice with patients. Placements are therefore characterised more as facilitation of patient-based experience, than didactic delivery of knowledge.

In summary, placements are characterised as experiential knowledge. Both engaging the experiential knowledge of patient's ill-health in teaching, and legitimising the experience of students as a learning tool to teach and rehearse during placements. As will be explored below, this positions the GP teacher not as a didactic source of knowledge to be taught to students, but rather as a facilitator of learning through organising student experiences of patient interaction.

Subject with contextualised disease

Patients, sometimes referred to as 'real' are produced within this gaze as providing students with knowledge about contextualised disease, in contrast to treating patients as a disease object or 'case'. This subject position is said to provide different, but at times related, elements of learning for the student. First, subject with contextualised disease is said to provide knowledge that is embodied, rather than separate from a patient's life. Second, knowledge about the patient with disease as distributed or socially situated. Third, a subject

with contextualised disease is said to provide knowledge relevant to professional practice. I will now examine each of these in turn.

Patients with contextualised disease are treated as an *embodied* exemplar of disease. Rather than the student attending only to the classification and treatment of disease, they are concerned also with the situated experience of that particular patient and how their lived experience might shape their focus and possibilities for treatment. In this text, for example, reporting patient experiences of participation in general practice medical education, patients were said to draw a distinction between the knowledge they were able to offer students, and alternative sources:

> *"**Patients recognised that they exemplified diseases better than books** did and could help students learn …." (Ashley, 2008, p. 26)*

Patients with contextualised disease are also treated as *distributed* or socially situated. The relationship between the patient with an illness or disease and their home, family or work life is said to become an important aspect of the teaching interaction. The student's attention is drawn to the particularity of a patient's illness experience and the way in which this is shaped by the contextual variants of their particular life and social arrangements. This text, for example, explores how patients perceive their role and utility within general practice teaching encounters. It highlights different elements of knowledge the patient 'offers' including their physical body; the embodied disease; and the relationship between their illness and lives:

> *"Patients suggest they offer the students their **body** as an educational resource, the **context of their illness** and how it presents (**authenticity**) and an insight into how illness fits within the **context of their lives**."*
> *(Lucas and Pearson, 2012, p. 280)*

The subject with contextualised disease is also said to provide knowledge relevant to professional practice, in contrast to knowledge just required to pass exams. This subject position is associated with the positioning of general practice placements as 'real' and as preparation for professional practice. This text, for example, reports student focus groups following problem-based learning with patients in the general practice setting. The subject with contextualised disease is said here to support students' learning about the application and relevance of knowledge to a particular patient:

*"**Real patients** gave a strong **contextualisation** and **relevance** to the learning process....**Real patients** brought **interest, purpose and motivation**... **Real patients** also brought **focus** ... on important issues and finding answers relevant to the patient" (Dammers, 2001, p. 30)*

In summary, the subject with contextualised disease is produced within texts as a particular feature of general practice placements when characterised through a gaze of discovery. The subject with contextualised disease is said to provide knowledge about three different, but related areas. These are contextualised disease as embodied in a particular patient. Next, contextualised disease as interconnected or distributed within a particular social setting; and lastly as relevant beyond exams to relevant application of knowledge in professional practice.

Subject who educates

In the previous category, I examined how a subject with contextualised disease is produced within texts. This legitimates, within this gaze, a student attending to the experiential knowledge of a patient. It also produces a related position for the patient as 'subject who educates': legitimating the experiential knowledge of the patient makes available a position for them as patient educator. This text, for example, positions the patient as able to contribute to the students' learning beyond being an example of a disease specimen:

*"A living torso is better than these ... **automatic models**, and also it is better than **somebody who is in hospital** ... Apart from the fact that the person in hospital wants to curl up and go to sleep or something ... I can answer their questions you see, and I **know a little bit** about what is going on."*
(Lucas and Pearson, 2012, p. 280)

A contrast is made between the position available to the patient as an active contributor to medical education in the general practice and hospital placement. The patient as a 'living torso' or contextualised disease is said to be more able to interact due to their severity of illness in the general practice setting, but also able to share their knowledge about 'what is going on'. Legitimising experiential knowledge within the general practice placement produces a position for the patient as 'educator', teaching the student about their experiences and perspectives. The availability of this position for the patient as subject who educates is dependent upon how the placement is characterised (what is said to be taught and learnt). This next text is from a study exploring patient experiences of teaching in

general practice placements. Here, the text treats the availability of the 'subject who educates' position for the patient, as dependent upon the focus of the clinical teacher. In shifting the students' attention to include the relevance of a patient's experiential knowledge, the patient feels able to participate in the teaching, and 'teach the students':

> *"Patients can be treated as objects of practice, or subjects in practice…. These students need to learn and so they're going to look at this object, whereas* ***if your physician involves you [the patient] then you become part of the teaching****, you know,* ***you can teach the students as well****, you know, it's quite a different experience." (McLachlan, 2012, p. 969)*

In summary, through this gaze, experiential knowledge is made legitimate as an aspect of what is taught and learnt during general practice placements. This produces a position for the patient as 'subject who educates' valuing the experiential knowledge they can share with the student during their teaching encounter. A combined attention to the patient's disease and its situated nature legitimates the experiential knowledge of the patient, and thereby inclusion of their expertise in the teaching encounter. Not only is the GP 'teacher' offered a position as 'subject who educates', but also the patient.

Participatory Learner

Characterising general practice placements as experiential, interactive learning for students and rehearsal of professional practice, produces a position for the student as 'participatory learner'. This participation is characterised as exchange of knowledge about the patient's experiences through talk, but also student participation in physical interaction with the patient through examination of their body. I will examine both these elements. First, through participatory experience, the student is said to learn and rehearse talk interaction with patients. This study, for example, explores student experiences of teaching contrasting hospital and general practice placements. General practice placements are said to provide an opportunity for students to learn about patients' experiences through practical participation in student-patient interaction:

> *"..the community placement was praised as* ***having encouraged students to recognise the relevance of addressing patient concerns*** *as well as the* ***opportunity to 'practise'*** *this in an environment in which they felt comfortable." (Thistlethwaite, 1999, pp. 683-4)*

General practice placements are also said to provide opportunities for physical interaction with patients. The student is not only said to rehearse interaction and talk, but also touch, gaining 'hands-on experience' with patients, rehearsing to be a professional practitioner:

> *"They [patients] were also sensitive to **the students' needs**. Patients' perceptions of the importance of offering this body within the context of medical education were clearly evident…**representing their body** as a 'guinea pig' or 'living torso' **for 'hands on experience'**." (Lucas and Pearson, 2012, p. 280)*

Participatory learning in the teaching encounter is characterised as supporting a transition in student learning, towards the purpose of professional practice. The process of experiencing interaction with patients through talk and touch, rehearsing the role of doctor, shifting their position towards, or even transiently being positioned as, a professional doctor. In this text, for example, exploring patient participation in general practice clinics, the position of 'participatory learner' is associated with students feeling like a professional and an associated sense of reward at being able to help a patient:

> *"Seeing patients before the consultation proper **challenged students to participate as a doctor-to-be**; for one typical respondent it was 'the most rewarding thing – **speaking to patients on my own** and then actually **feeling like I'd contributed to why they were there and to the job of doctor and I'd actually really helped**'." (Ashley, 2008, p. 28)*

This position as participatory learner, interacting with patients as people in both the general practice and home context is also associated with facing some professional challenges. In this text, for example, the student's sense of responsibility and care for the patient during participatory learning is contrasted with the more passive position offered to the student during paper-based teaching:

> *"Students felt increased feelings of **responsibility**... to obtain an accurate account and to challenge assumptions and prejudices generated by the written summary... '**Real people** generate **real feelings in health care professionals'** ... 'It made a huge difference to know they are **real people**, particularly when visiting them and to realise that **people aren't textbook cases but far more complicated and interesting**'... **Real patients** brought an **empathic and***

***humane dimension**, fostering a **patient-centred perspective**."*
(Dammers, 2001, p. 30)

The students' learning through participation is positioned as preparation for professional practice, highlighting the complexities applying theory into practice. In contrast to paper-based learning in the university setting, the subject as participatory learner is said to make visible to the student the complex and relational elements of patient interaction in the general practice setting. This is associated with an increased sense of responsibility to use and learn knowledge accurately, making visible to the student the direct human impact of the learner's actions on others' well-being.

Student participation during general practice placements is also positioned at times within texts as a way of shaping students' career aspirations, promoting general practice as a professional career. The text below, for example, reports a study conducted in a deprived, urban area. GPs are said to be engaging in teaching as a way of making their work visible to students through their experiences in the practice as a student:

*"General practitioners also suggested that **undergraduate experience of primary care** in the Black Country would not **only raise the profile of primary care** in the Black Country, but would **encourage students to return as graduates if they had enjoyed placements within 'good' practices and thereby come to realize the potential for working within the area**." (Mathers, 2004, p. 1222)*

In summary, the subject position of 'participatory learner' is characterised within this gaze both as interaction with patients and physical touch and examination of patients' bodies. It is also, at times, characterised as student participation in learning with the practice organisation. This subject position is said to enable students to learn about being a professional and experience some of the rewards (such as feeling they are able to help patients) and challenges (such as responsibility) associated with this professional engagement. It is also positioned as a way of encouraging students to consider a career in general practice or in a particular geographical area.

Subject as intruder or disruption to the GP-patient consultation

So far, I have examined how characterising placements through a gaze of discovery produces a range of particular ways for learning. In this section, I examine how integration of

teaching and service, engaging students in professional practice with patients, is sometimes produced within texts as problematic. I examine how, through a gaze of discovery, a subject position can be produced for the student as an intruder or disruption. A consultation between GP and patient is treated as 'normal' and, by contrast, the presence of a student in the consultation 'abnormal'. A student's presence is treated as making the consultation more public; requiring special permission or consent from a patient; changing the nature of the GP-patient interaction; and changing the possible outcome of the consultation.

This subject position is more evident in texts that position the student as an observer, rather than active participant: the student observing the GP, rather than conducting or directly participating in the consultation with the patient. The GP-patient interaction is treated as a pre-existing norm, into which the student is introduced as a 'third party'. Once the GP-patient encounter is conceptualised as the norm, the effects of the intervention or introduction of a student 'third party' can be measured. In this recent text, for example, the paper examines the effects of a student intervention on patient experiences of quality of care:

> *" Inevitably, the introduction of a **third party** into the consultation will influence the **relationship between doctor and patient**, and previous authors have expressed **concern about the possible impact of student presence** on the quality of care experienced by the patient (Higgs, 1995)..... [We examined the] effect that a student sitting in on a **normal general practice** consultation may have on the perceived quality of the **care experienced by the patient**."*
> *(Price, 2008, p. 375)*

The impact of the introduction of a student into the GP-patient encounter is measured in various ways within texts, looking at both operational and perceived changes. Price and colleagues, for example, examine the impact of a student's presence on patient's experiences of enablement and empathy during a teaching consultation. Here, the student's presence is said to reduce the patient's sense of GP empathy or extent to which the GP is perceived to understand the patient's world and act on this is in a therapeutic way. The degree to which a patient feels helped by their GP to understand the nature of their illness is said to be slightly different:

> *"We looked at the **effect of student presence** on 2 measures of **quality of care**. …Our findings would appear to show that the presence of a medical student as an **observer of a consultation** does not adversely affect the quality*

*of the normal GP consultation as experienced by the patient. Although there was a statistically significant **reduction in empathy**, and a difference approaching significance for **enablement,** these differences were small and unlikely to be of practical importance. " (Price, 2008, p. 375 and 378)*

The impact of a student on the 'normal' GP-patient encounter, has been measured in other ways, including audit of GP management with and without students present. Here the GP's 'normal' practice is said to change in the presence of a student. The GP is reported to be less likely to give a prescription: something looked upon favourably by the medical profession, but perhaps not by a consulting patient. A student's presence is also said to disrupt the closure of the relationship between GP and patient, resulting in more investigations and postponing a decision to communicate through referral with hospital peers:

*"...a **patient seen in a teaching consultation** is **less likely to get a prescription** than if he is seen by the same doctor in a routine service; at the same time he is **more likely** to have some form of **investigation or to be followed up**... I had also expected more referrals in the teaching situation but instead there were fewer...This could either mean that the **teaching doctor felt he could cope** with more problems himself, with the **help of his students** or that there was a tendency to postpone the decision to refer until a follow up consultation perhaps **without a student**." (Freeman, 1981, p. 113)*

The student is positioned as disrupting the way in which the GP interacts with the patient. The student's disruption is characterised as shifting the attention and position of the GP. This disruption is said to shift the GP's position from being aligned with the patient (fulfilling for example their request for a prescription), aligning their position more with medical colleagues, through having a trainee member witnessing their practice (for example asking for investigations to increase diagnostic certainty).

The production of the student as an intruder or a disruption is also characterised within texts as dependent upon the characteristics of the patient and student. The student, for example, is more likely to be positioned as a subject who intrudes if the patient is female, or bringing a particular problem to the consultation, which is treated as more private. This text, for example, from the 1970s, reports a study exploring patients' attitudes to medical students' presence in general practice consultations. The gender of the patient is said to impact on

how much is revealed by the patient during the teaching consultation. The effects of the student's intrusion are said to not always be made apparent to the clinician at the time of consulting, only indicated in this example by 'non-verbal communication' cues:

> *"These findings suggest that the **presence of undergraduate students in general practice carries important implications**. Firstly**, the presence of a student may complicate the task** of eliciting relevant psychosocial components at consultation. This appears to be **particularly so with women**.... Secondly, the general-practitioner teacher must constantly **monitor the effects that the student's presence is having on his patien**t – which may be indicated by much non-verbal communication. Certainly, patients will rarely (if ever) directly ask the doctor if they may consult him alone. ...**When the student is introduced, therefore, perhaps the simplest and most effective practice is for the doctor to ask his patients routinely** whether they wish to consult him alone."*
>
> *(Wright, 1974, p. 376)*

The extent of the student's intrusion is also treated as conditional upon the nature of the patient's problem. A student's presence is said, for example, not to affect communication between GP and patient about physical symptoms, but is said to 'complicate' the process of exchange about psychosocial concerns, 'sexual problems', 'personal anxieties or family problems', 'money problems', and 'work problems' (Wright, 1974, p. 373). These 'problems' are produced within texts as something more 'personal' and thereby not appropriate to the territory of a more public (student) encounter. Female patients are positioned as less readily accessible to the student, or perhaps more sensitive to the intrusion of an additional subject. The 'reluctance' to include a student in the encounter was, for example, predominantly in women, preferring 'not to discuss contraception, possible pregnancy, and abortion, when a student was present' (Wright, 1974, p. 373). This treatment of the student as intruder produces an imperative from these research findings, recommending that GPs should always 'ask' patients about student presence.

The nature of the student's intrusion is said to be dependent, not only upon the complaint and characteristics of the patient, but also the characteristics of the student. Here is a more recent text from an observational and interview study exploring the impact of student general practice placements on patients:

> *"Two interrelated aspects of consent emerged: the **specific information** given to patients before seeking their consent and the **point at which consent** is sought. Participants wanted to know the sex and number of students, although this information was rarely provided. Information about students' **competence and experience** and the likely nature of the consultation or examination were also felt necessary for truly informed consent." (Benson J, 2005, p. 4)*

Once positioned as abnormal and an additional intruder to the consultation, the student's presence requires patient *consent*. The consultation is treated as belonging to the patient, and the student's participation dependent upon the patient's decision. While sometimes the consent decision is dependent upon the nature of the patient's complaint, at other times it is conditional upon the student. A student is treated as acceptable to include in the consultation only in certain circumstances, dependent upon gender; student numbers; student competence and experience; and what the student might do during the encounter. A novice group of students becomes treated as more disruptive, for example, than an experienced, more senior, single student.

In summary, student learning within routine GP-patient consultations is positioned at times within texts as problematic. A GP-patient interaction is normalised, treating the student's presence as an addition and thereby potential intrusion or disruption to a 'normal' clinical consultation. The student is treated as disrupting the interaction between the GP and patient, as well as the operational outcomes of a consultation and GP's interaction with hospital-based colleagues. Positioning the student as a subject who intrudes, produces a requirement for patient 'consent' for the student to be present. This consent is said to be conditional upon the nature of the patient and their complaint, and the characteristics of the intruder.

Subject as facilitator of learning

The characterisation of general practice placements through a gaze of discovery produces two important positions for the GP as teacher. The first is to produce an integrated position for the GP as both provider of clinical service *and* teaching, rather than these roles being conceptually divided. In this text, for example, the student is said to witness the GP engaging in service appointments with patients as part of the GP teacher's role. This integration is said to give the student insight into the GP's work with patients and how this may (or may not) fit the students' own career aspirations:

*"'The third GP I really respected; he really **made me think that I could be a GP**; he **did so much for the patients** and was **so involved in them'**. Another [student] noted: 'I've got a **picture of the GP's life** – the work was harder than I expected." (Mattson, 1991, p. 146)*

A second position offered within this gaze to the GP-teacher is 'facilitator of learning'. The GP is positioned not as delivering knowledge directly to the student, but rather facilitating their interaction with patients and thereby enabling them to learn through experience. In this text, for example, the GP is positioned as carefully structuring various elements of knowledge, in preparation for the students' interaction with the patient:

*"Doctors could **promote participation by orientating a student to a patient's disease, identifying the student's level of knowledge** about it and **their learning needs**, **helping them contextualize existing knowledge to the patient**, **providing a scaffolding for new learning**, and **establishing how ready they were to take on an active role**; 'I felt that with my consultation it was more like a **partnership between me and the doctor** and we talked about it quite a lot before a patient came in…'." (Ashley, 2008, p. 28)*

In the position of 'subject who facilitates learning', the GP is said to attend to the particular learning needs of the student. This text, for example, explored the experiences of novice teachers learning to teach, describing the GP novice teacher as placing responsibility upon the students to determine what they ultimately need to know:

*"The data provided evidence that participants [GPs] had **increasingly learnt to attend to students' needs and priorities for acquiring knowledge**. One **GP participant acknowledged coming to appreciate that students would know 'what would be useful**, because ultimately it's them that can say whether that was what they needed or not." (Cook, 2009, p. 611)*

This facilitatory approach to teaching places emphasis not upon the GP's knowledge, but on the value of the patient's knowledge (and thereby their position as subject who educates) and the student as participatory learner identifying their learning needs and engaging in professional interactions. This emphasis treats the GP as 'facilitator of learning' as aiming to minimise the student's requirement for and dependence upon the GP teacher during learning. GP teachers are said, for example, within this gaze, to be aiming towards the

students interacting independently with the patients, without having to defer to another's professional knowledge:

> *"**GPs saw the goal of medical training as being 'safe independent practice'** and **being able to manage a range of problems without feeling 'that you've got to prescribe, or refer, or pass (it) on to someone else**."*
> *(Howe, 2002, p. 382)*

In summary, the GP is characterised within this gaze as an integrated GP-teacher, making visible to students the nature of their work as a GP. GPs are also offered a subject position as 'facilitator of learning', attributing value to the experiences of patients and experiential learning of students, rather than making visible their own knowledge-base. This is said to aim towards students developing an ability to practice independently as professionals, making the nature of professional practice visible to the students through experience.

Workplace-based learning

There is a logic used within a gaze of discovery, which treats what is learnt by students as generated through observation and interaction with professional practice, rather than compartmentalised or pre-determined by university faculty. Placements are characterised as experiential learning and producing a subject position for the student as 'participatory learner'. This text, for example, exploring patient participation in general practice teaching, describes workplace learning in general practice placements as participatory:

> *"We have previously explored medical students' **workplace learning** and defined **supported participation as its core condition** (Dornan, 2005a; Dornan, 2005b)." (Ashley, 2008, p. 25)*

Participation in the general practice workplace is said to provide learning for students about processes such as decision-making and application of knowledge to practice. Similarly, placements are said to include prioritisation and balancing of different knowledge forms encountered during clinical consultations, rather than focusing upon a particular knowledge compartment. This text, for example, reports how students formulated their learning about patients broadly, drawing upon a variety of relevant disciplinary knowledge:

> *"Using **real patients** may generate anxieties for faculty that learning will be directed towards **clinical**, **sociological and humanistic** areas of study... We*

> *observed that students recognised the need to maintain a* ***balance of clinical medicine****,* ***basic sciences, and ethical, legal and sociocultural aspects*** *in the formulation of learning objectives related to individual patients."*
> *(Dammers, 2001, p. 32)*

This text highlights a tension between pre-determined and patient-based ways of characterising learning. Patient-based learning is said to 'generate anxieties' for university or disciplinary-based organisation of knowledge, attempting to ensure coverage of different curricula areas. General practice placements are, thereby, positioned as reducing faculty control of teaching agendas, requiring greater trust in student-directed learning goals. General practice placements are, however, characterised as supporting the students' ability to negotiate and prioritise a range of different knowledge forms through experience of professional practice.

The nature of professional learning is made distinct within texts, contrasting general practice placements with both exam-orientated learning, and hospital placements. I will examine each of these in turn. First, professional learning in general practice placements is said to provide 'real world learning', rather than teaching orientated to assessment. This text, for example, interviewed GP teachers, patients and students about medical education, including general practice placements:

> *"Both staff and users emphasized the community setting as being the '****real world'****. Users [patients] affirmed their view that students should 'get (down) to grass roots … they're [students are]* ***apt to lose sight of what happens in the real world'****, because otherwise they were '…****just worried about passing exams and not really thinking about life'****." (Howe, 2002, p. 383)*

A distinction is also made between general practice placements as workplace-based learning, and hospital placements as more orientated to a structured curriculum. In this text, for example, a distinction is made between the learning culture in the two settings, emphasising the importance of experiential learning as a way of teaching students about the working context of general practice. The text also describes a tension reported by GP participants, between a pre-determined approach to teaching and the breadth and 'multi-systemic' experiential learning in the generalist setting:

"GP tutors … recommended ***more contact with their own working contexts****: 'a shame they can't live in the practice part of the time'. '****they come to us indoctrinated… and it takes a while to break that down'****… GPs perceived some conflicts between the* ***requirements of a structured course with specific clinical content****: 'driving test medicine, where you have to be seen to do the things that people are looking out for, you have to tick the boxes', and* ***learning from experience in primary care, which is multi-systemic and has a very broad case mix****." (Howe, 2002)*

In summary, a logic of workplace-based learning underpins the characterisation of general practice placements through a discovery gaze. Placements are, for example, characterised as learning how to negotiate use of a range of different disciplinary knowledge, or learning with 'real' patients. A distinction is made between general practice placements as workplace-based learning, preparing students for professional practice, and hospital-based learning as more structured teaching, orientated towards assessment. This produces a potential dyad within texts, polarising learning relevant to exams to hospital placements, producing general practice placements as 'not exam relevant'.

Conclusion

In conclusion, there are two ways in which general practice placements are characterised within this thesis. Foucault uses the term a 'gaze of discovery' in relation to contemporaneous discovery of patients by students and clinician in the hospital teaching context. I have used this term to present my examination of one way in which general practice placements are characterised within this discursive field of research texts about general practice placements (see Table 1). The object of general practice placements are characterised within this gaze as patient-based interaction and experiential learning. This produces a range of subject positions including 'subject as contextualised disease' and 'subject who educates' for patients. Students are offered positions as 'participatory learner' and 'intruder or disruption'. GPs are offered positions as integrated GP-teacher and 'facilitator of learning'. A logic of workplace-based learning is used to characterise general practice placements through this gaze, engaging and preparing students for professional practice.

Object: general practice placements characterised as…	**Subject positions produced**	**Concepts or Logics**
Patient-based interaction	Patient as subject with contextualised disease: • embodied • distributed or socially situated • providing knowledge relevant to professional practice	Workplace-based learning
Experiential knowledge	Patient as subject who educates	
	Student as participatory learner	
	Student as intruder or disruption to the GP-patient consultation	
	GP as facilitator of learning	
	GP as integrated teacher-clinician	

Table 1: Summary of Analytical Categories for a 'Gaze of Discovery'

Chapter 4: Gaze of Deciphering

Introduction

In this chapter, I again address the research question about what is said to be taught and learnt in the general practice placement, but this time examine how this discursive field produces general practice placements as through a 'gaze of deciphering'. This produces what is said to be taught and learnt in general practice placements as pre-determined and compartmentalised prior to the placement encounter.

Foucault, in his description of the shift in the organisation of clinical experience within medical education, describes the 18th century 'clinic':

> *"[The clinic's] task is not to indicate individual cases, with their dramatic points and their particular characteristics, but to manifest the complete circle of diseases… [The clinic] was organized in such a way that 'those cases that seem most instructive' could be brought together… A structured nosological field….It was not the direct expression of the hospital…[tending] to prefer those cases that have high instructive value. By operating a process of selection, it alters in its very nature the way in which the disease is manifested, and the relationship between the disease and the patient; … In the hospital, the patient is the subject of his disease, that is, he is a case; in the clinic, where one is dealing with examples, the patient is the accident of his disease, the transitory object that it happens to have seized upon." (Foucault, 1973, p. 70)*

Foucault goes on to describe the purpose of medical education in the clinic as the ability to decipher and name disease:

> *"…the gaze that traverses a sick body attains the truth it seeks only by passing through the dogmatic stage of the name, in which a double truth is contained: the hidden, but already present truth of the disease and the enclosed truth that it is clearly deducible from the outcome and from the means. So it is not the gaze itself that has the power of analysis and synthesis, but the synthetic truth of language which is added from the outside, as a reward for the vigilant gaze of the student… It is a question not of an examination, but of a deciphering." (Foucault, 1973, p. 72)*

In this chapter, I examine how the discursive field of research texts, produces general practice placements through a gaze of deciphering. As in Chapter 3, many ways in which general practice placements are characterised within texts, are through distinctions with hospital placements. Through a gaze of deciphering, placements are characterised as particular disciplinary components selecting, for example, a patient to exemplify a disease or curricular focus as a 'subject with disease'. A pedagogic logic is used which values pre-definition and categorisation of components of knowledge to be taught.

General practice placements as learning about disease

In Chapter 3, I examined how placements were characterised as learning about professional practice or workplace-based learning, including production of a position for patients as subject with contextualised disease. In contrast, through a deciphering gaze, placements are characterised as teaching about a particular disease component. In this section I examine the various ways in which general practice placements are characterised as teaching about 'disease'.

General practice placement 'disease' knowledge is characterised as different to hospital placement disease knowledge in a number of ways. General practice placements are characterised as teaching about long-term or chronic disease, treating management as slow-paced prevention and minimisation of complications rather than cure. In contrast, hospital placements are characterised as acute or severe disease, with the prospect of cure. There are instances where general practice placements are characterised as 'acute disease', but made different through their treatment also as multiple co-existing disease, or multi-morbidity. General practice placements are sometimes characterised as teaching about a specific disease condition, similar to a hospital speciality placement. However, it is made different as 'basic', rather than specialised knowledge. This separates the work of the GP as teacher and clinician, using pre-selected patients for teaching, relevant to a particular curricular component. I will now examine each of these features in turn.

First, I will examine how general practice placements are characterised as 'chronic disease'. This characterisation is continuous across the discursive field. Here are two examples, the first from 1970s and a second more recent text. This first text, reports the development and evaluation (using a questionnaire and multiple choice exam) of the first general practice placements in Glasgow medical school, within the formal curricula timetable. The paper lists the formulation of course objectives. Objectives 2-4 read:

*(2) To demonstrate conditions **not frequently seen in hospital** but which carry considerable morbidity in the community.*
*(3) To show the measures which can be taken in the **prevention of long-term** deterioration in the health of patients*
*(4) To demonstrate what is involved in the **long-term care of chronic disease**"*
(Barber, 1973, p. 166)

Disease knowledge encountered in general practice placements is treated as prevention of disease, and care of long-term conditions to prevent or minimise progression of complications. A distinction is made between the types of disease producing 'considerable morbidity' in general practice, and the hospital. General practice placements are characterised as what is *not* available in hospital.

Within a gaze of deciphering, placements are characterised as providing learning about a specific component of knowledge, here 'disease'. Most often, this is said to be pre-defined through curricula objective setting. Barber (above), for example, characterises placements using reported curricula objectives of teaching. Some texts, however, characterise placements as a 'disease' component using research findings, such as reported measurement of student and tutor disease encounters during placements. This next text, for example, characterises placements as 'chronic disease' using student and tutor reported disease encounters during an internal medical general practice placement. Characterising placements in this way is then used to make recommendations about how placements might be characterised in future:

*"The diagnoses that were reported in both models tended to be **related to chronic diseases** rather than to acute illnesses." (Bryant, 2008, p. 47)*

There are occasional instances, where general practice placements are characterised as learning about acute disease. The nature of the disease is, however, made distinct from hospital placements in a number of ways including the range of morbidity or variety of disease conditions, and the stage or development of disease. This contrasts with the hospital placements as predominantly acute disease, most of which is curable, focused upon a particular condition and within a narrow range of stage or severity. This text is from Glasgow medical school reporting a new general practice placement:

*"The students are present at the patient's initial consultation for an **acute illness** and thus see a wide **range of morbidity** which is seldom found in hospital.... The students saw only the first presentation of new illness, representative of that seen in general practice (Morrell, 1971) and involving a **variety of complaints** in all age groups. This **range of morbidity and this stage of illness can only be seen in general practice.**" (Murray, 1976, p. 687 and 690)*

Another way in which general practice placements are characterised is as a category of a particular disease or disease relating to a specific body system. This contrasts from the previous broad categories of chronic and acute, by mirroring hospital placement organisation of disease specialities. This requires a different organisation of general practice placements: whereas teaching about the categories of acute and chronic disease might occur in conjunction with 'routine' general practice service clinics, the characterisation of general practice placements as specialist disease requires separation of teaching and service: teaching during protected time with selected patients:

*"The teaching was designed to ensure that **diseases of the major body systems**, with a focus on cardiac and respiratory systems, were **systematically** addressed.... In routine [core general practice] sessions, students would be taught on any **patient that presented**. In the structured sessions, tutors arranged for students to see **selected patients** who were able to **demonstrate histories or signs that were relevant to the course**." (Bryant, 2008, p. 45)*

A tension is produced between provision of placements that co-exist with professional, clinical practice, and separation of teaching and service. When viewed as specialised disease, placements are compartmentalised to fulfil the needs of a pre-determined curriculum, focusing on for example Women's Health or Heart Failure, rather than learning through meeting patients' clinical needs during a routine surgery. Here are two examples. The first text is a recent paper, making a distinction between 'routine' and structured' teaching:

*"**Routine general practice consultations** were defined as **patient-initiated consultations** in which a student was present 'sitting in' with the GP to observe or take part in the consultation. **Structured teaching** was **defined as tutor-initiated** consultations in which the tutor **invited the patient with a specific relevant condition** to take part in the teaching session. There were **specific***

> ***aims and objectives for teaching sessions*** *and routine clinical work was covered by someone else in the practice." (Bryant, 2008, p. 46)*

This distinction between 'routine' and 'selected' teaching approaches is evident as far back as the 1970s:

> *"The teaching methods used by the tutors were variable except that they all had agreed that the* ***teaching would not be conducted during normal surgeries*** *or visit rounds....each tutor agreed to teach as many of a* ***preselected list of conditions*** *as he could, relating his teaching to the five objectives of the course. For each teaching session three or four* ***patients were selected*** *and the planned nature of the teaching allowed the patient's consent to be obtained in advance. It also permitted the* ***tutor to prepare his presentation of the patient****."*
> *(Barber, 1973, p. 167)*

This produces two subject positions for patients. One is 'subject with disease': a subject with a specific disease, relevant to the curricular aims for the placement, is produced as a legitimate focus of the student's attention. Patients are pre-selected and prepared prior to teaching, and the focus of the encounter determined by the curricular needs of the session. This offers short-term benefits in terms of accountability and measurement of students' learning, but produces significant tensions with professional practice. A second position is 'subject without disease'. A routinely attending patient may have a lack of disease, or concern with a number of conditions - many of which may be 'irrelevant' to the curricular focus - rather than one specific disease. A patient who has, for example, medically unexplained symptoms or multi-morbidity, although common in practice, becomes an irrelevance or disruption to learning.

In summary, general practice placements are characterised as providing teaching about disease. The nature of this disease is characterised most commonly as chronic. Occasionally, disease is characterised as acute, but further distinctions are then made in relation to its difference from hospital placements including the presence of multiple, less severe conditions. A further way in which placements are characterised is providing not just teaching about disease, but a specific category of disease, relevant to a curricula topic. This produces a significant split between the routine clinical work of general practice and provision of teaching using selected patients to address the pre-determined needs of the curriculum.

General practice placements as interactional knowledge

In Chapter 3, I examined how, through a discovery gaze, general practice placements are characterised as providing integrated teaching in which interactional knowledge, such as social implications of disease, are integrated within the students' encounter with a patient with ill-health. In this section, I examine how, through a gaze of deciphering, general practice placements are characterised as providing interactional knowledge as a specific, discrete curriculum compartment. A Cartesian mind-body split is used to polarise teaching, locating students' learning about physical disease and interactional knowledge in different physical and curricular locations. Rather than emphasising commonalities of learning across general practice and hospital placements, or positioning interactional knowledge as one aspect of teaching during a placement, general practice placements, through a deciphering gaze, are treated as supplementing hospital teaching providing *only* interactional knowledge, which has not been taught in the hospital setting. In this section, I map three common ways in which general practice placements are characterised as forms of interactional knowledge: psycho-social, attitudes, and communication.

General practice placements as psycho-social knowledge

In this section, I examine how general practice placements are characterised as providing teaching about patients' psychological and social well-being. Within this field, as in many other texts about medical education, a Cartesian division between learning about mind and body is made thinkable through categorisation of clinical knowledge as separate components. Here, for example, is a text from the 1970s listing objectives for a general practice placement:

> *"To demonstrate that a 'diagnosis' has **physical, psychological and social components**." (Barber, 1973, p. 166)*

Once divided, it becomes possible to imagine different aspects of teaching about these categories in different spaces. General practice is identified as a space in which psycho-social knowledge is available for students to learn. Here, for example, student logs are used to categorise student experiences as two separate components 'the diagnosis that is made *and* the presence of significant social and psychological aspects of the physical condition.' (Murray, 1976, p. 687):

*"In the history-taking [students] noticed that the main emphasis was given to the system principally involved with more time being spent on **patient's social history**.... Much surprise was expressed at the number of **psychosomatic complaints** and at the number of complaints with a **social component**.... The students were able to appreciate the **social or psychological factors** which appeared of importance in the patient's presentation of illness."*
(Murray, 1976, pp. 689-690)

The characterisation of general practice placements as providing psycho-social knowledge is evident across the genealogical range of texts. Here is a more recent text showing how general practice placements continue to be characterised as providing psycho-social knowledge, in contrast to hospital placements, following student experiences in general practice:

*"Respondents were almost unanimous in their opinion that their community firm had heightened their awareness of **psychosocial issues** in relation to health and illness. They attributed this to three factors. Firstly, their tutors raised the issues during formal teaching sessions. Secondly, they **observed** their tutors dealing with these issues when the students sat in on consultations. Thirdly, and most importantly, students felt that having an hour or more **with patients** to take a history enabled them to ask about these issues in depth.… and were able to see at first hand the ways in which **illness could impact upon the individual and the family.**" (O'Sullivan, 2000, p. 653)*

There are several ways in which psycho-social knowledge is said to be made visible to students during their experience in general practice. Students observe GPs in practice and the attention they give to psycho-social aspects of patients' care. Students also experience this first hand, when conducting their own consultations with patients and learning about how an illness impacts on the patient's life. Attention to psycho-social elements is also made explicit during formal aspects of teaching. This association, however, changes the nature of learning and relation with hospital placements, when general practice placements become characterised as providing teaching *only* about psycho-social knowledge. Here, for example, is a text reporting student and tutor expectations of teaching during a general practice placement:

*"The results of the study show that students expected the **general practice / social medicine** course to contribute most to their development of the more complex skills of integrating clinical knowledge, making clinical decisions, devising management plans and increasing their **awareness of the psychological and social aspects of ill-health**....They expected less from the course in terms of developing clinical knowledge and practical skills ...The finding that students did not feel that their general practice attachment helped them to develop practical skills does **not imply that these skills cannot be learned effectively in general practice**, but it more probably reflects that in the short time available they are **not given priority by tutors**, who expected them to be taught in **other parts of the medical curriculum**." (Lloyd, 1992, p. 493)*

Through a deciphering gaze, teaching is said to be prioritised to address *only* those areas *not* thought to be taught well by the hospital. In Lloyd's text, for example, the nomenclature for the placement uses 'social medicine' interchangeably with general practice placement. Given the short amount of time allocated to general practice, students' attention is drawn to psycho-social aspects of ill-health, filling perceived gaps within hospital teaching. It then becomes thinkable for students to associate general practice placements *only* with psycho-social knowledge. The status of psycho-social knowledge in relation to teaching about physical disease is problematic. This dyadic characterisation of placements is said in some texts to produce a hierarchical view of the importance and status of hospital and general practice learning:

*"Some **association emerged** in this study of close integration with **behavioural science with adverse student reaction to the early patient contact course** [in general practice] itself." (Mowat, 1996, p. 306)*

In summary, a Cartesian division of learning about patients makes it thinkable that learning about physical and psycho-social care might happen in different physical and curricula spaces. General practice placements are characterised within this discursive field through a range of techniques including reported student expectations, reported experiences and curricula course aims, as a space that offers learning about psycho-social knowledge. Once treated as supplementing hospital-based teaching with limited curricular time, general practice placements become identified as teaching *only* psycho-social knowledge. This produces a dyadic hierarchical relationship between hospital and general practice teaching and the type of knowledge identified as available in each setting.

General practice placements as learning about attitudes

In this section, I examine how, through a deciphering gaze, knowledge is compartmentalised as knowledge, skills and attitudes, characterising general practice placements as teaching about attitudes. In the previous section, I examined how the compartmentalisation of clinical knowledge using a Cartesian divide of mind and body, enabled different forms of knowledge to be thinkable and teachable in different spaces. Another common divide, within this field and medical education texts more generally, is the categorisation of teaching as different elements of knowledge. Here, for example, is an extract from the opening paragraph of a text evaluating attitudinal change of students following a general practice placement in Oxford:

> *"Of the three objectives of medical education, to impart **knowledge, skills and attitudes**, the last is the most neglected. Moreover, like other aspects of education, **attitudes are more 'learned' than 'taught'**, through contact with teachers and peers, a process known as '**socialisation**' (Harris, 1974)."*
> *(Fowler, 1980, p. 301)*

Through the division of knowledge, the categories of 'attitudes' and 'skills' become treated as 'not knowledge'. These different elements are associated with different teaching methods. Acquisition of 'knowledge' is associated with teacher delivery, whereas acquisition of 'attitudes' is treated as something learnt more through interaction with professional colleagues. This separation of knowledge compartments, and association with different teaching methods, makes it thinkable that these different elements might be located to different spaces in the curriculum. General practice placements are characterised as producing attitudinal change or learning, in relation to general practice patients. A shift in student attitudes towards patients is associated with students' familiarisation with patients during placements.

Direct interaction and 'personal' experience during placements are associated with positive changes in students' attitudes towards patients in general practice. This treats students' attitudes to others, not as a private or hidden matter, but as an explicit educational concern of the general practice placement. To demonstrate this category, I have chosen a text written by colleagues at UCL, designed to explore the impact of an undergraduate mental health placement in general practice, on student learning and attitudes. The aims of the placement are stated as:

*"To **broaden** students' **understanding, experience** of and **attitudes towards people** with common mental disorders in community settings."*
(Walters, 2007, p. 101)

General practice placements are characterised as producing a transformation in student attitudes towards patients, through their experiencing interaction with these individuals. Empathy is one element treated as a product of students' change in attitudes to patients following general practice placements. This is contrast with a decline in empathy more generally in medical education. Familiarisation with patients in general practice is associated with students' ability to better relate and understand another:

*"Over the last decade there has been an emphasis on the development of **appropriate attitudes** in the medical profession (GMC, 1995). Despite this, recent evidence has shown **a decline in empathy** among undergraduates over the course of their study (Hojat, 2004; Woloschuck, 2004).... There was a general sense of **greater empathy** and, in some cases, less **judgemental attitudes** towards people with mental health problems **after their [general practice] attachment**. This appeared to be due to a **greater understanding** of the impact of mental health problems on **people's lives**." (Walters, 2007, p. 105)*

Greater familiarity and understanding of the patient and their life experiences and context, are said to produce greater student empathy for patients and less 'judgemental' student attitudes. This change in attitudes is treated as a product of the student gaining greater knowledge about the patient, but also their perceiving the patient as more like them and thereby as 'normal'. Through a change in attitude during the placement, a subject position for patients is produced as 'subject who is normal'. This produces a subject position for patients through previous, contrasting, attitudes of students towards patients with, for example, mental illness as 'abnormal'. In this instance, this normality is established through the tutor's reported selection of patients to mirror the students' age and social class:

*"It was important to tutors to demonstrate to students how it is possible to be '**normal**', **function independently** and have a mental illness: 'If I can get some young middle-class people in for them so that they can **really relate** to this person and think yeah, that could be my cousin, or my friend, or **me**, and not see mental illness as something that just happens to **really mad people who are not related**." (Walters, 2007, p. 105)*

A patient is offered a subject position as 'normal' if they fulfil similarity with the student or a student family member, or have minimal explicit disease either due to its mild or hidden nature and the patient's ability to 'function independently' in society. By contrast, a hospital placement is associated with severe, explicit disease and 'really mad people'. A distinction is produced between abnormal and normal subjects dependent on their severity of disease and limitations this imposes on their ability to function. A general practice placement is characterised as producing a shift in student attitudes from perceiving themselves as different, to contending a notion of sameness. This way of producing subjects as normal or abnormal is interesting to consider in relation to how a student might make thinkable their own vulnerabilities in health; permissible ways of making this visible or not; and its potential impact on their ability to work.

In summary, one way in which general practice placements are characterised, through a deciphering gaze, is learning of attitudes. The notion of 'appropriate attitudes' and allocation of attitudinal learning, makes students' interactions with others an explicit educational concern of the general practice placement. The division of learning into 'knowledge', 'skills' and 'attitudes' and association with different teaching methods, locates 'not knowledge' and interactional learning with general practice placements, in contrast to teacher delivery of 'knowledge' in other spaces such as the hospital. General practice placements are characterised as changing student attitudes through making patients in this space more familiar and normal. This produces a subject position for patients as 'normal' and similar to students.

General practice placements as Communication

In this section, I examine how general practice placements are characterised as providing a compartment of knowledge about communication. I examine how communication knowledge is treated as something appropriately taught in general practice, rather than hospital, particularly due to the integrated nature of disease and communication in clinical encounters. I examine, however, the tension within texts between the stated importance of learning communication in contextualised general practice consultations and the characterisation of placements as providing specific teaching *only* about communication. I also examine how communication is referred to not as knowledge, but as *basic* skills and techniques, taught *early* in the curriculum, in contrast to the hospital.

Communication is treated within a gaze of deciphering as a separate compartment of knowledge within the medical curriculum. Here, for example, 'communication interview skills' are presented as an important set of skills to manipulate patient outcomes of consultations:

> *"Establishing **effective communication between doctor and patient** has been shown to influence patients' satisfaction with medical care, their **compliance with medical regimens and treatment outcomes** (Engler 1981). This recognition has led to a growth in the **systematic teaching of communication interview skills** within the medical curriculum." (Irwin, 1984, p. 90)*

Treated as a separate curricular component, communication becomes associated with the general practice setting as something *not* taught in hospital and taught only in general practice. Here, for example, general practice becomes identified as the first substantial introduction to communication knowledge for students:

> *"Students had **virtually no training in these skills of communication before their fourth-year G.P. clerkship**…. This was partly because of **pressure on curricular time** and partly because it **was believed that students would be better motivated to learn communication in a real clinical environment**."*
> *(Irwin, 1984, p. 91)*

Communication is treated as a 'skill', which is not taught to students until their general practice placement. This is attributed in part to limitations of curricular time (suggesting it is not a prioritised topic), but also to its potential integration, in the general practice placement, with other knowledge involved in clinical encounters.

There are a number of ways in which the provision of teaching about communication in the general practice placement is justified as appropriate to be taught in this setting, highlighting many of the complexities and contradictions between the characterisation of general practice placements through gazes of discovery and deciphering. One justification treats communication as of universal relevance across both hospital and general practice settings. This universality is used to position the teaching of this topic in the general practice as a privilege, providing a valued aspect of the curriculum:

*"One [GP teacher] expressed particular satisfaction with the '**entrustment** of General Practice' by faculty with the **teaching of communication skills as they affect all clinical encounters**." (Mowat, 1996, p. 306)*

There are, however, a number of problems produced by the association of communication knowledge with general practice placements. One issue, for example, relates to the length of time said within texts to be allocated to general practice placements. When this is only small, general practice placements become identified *only* with certain compartments of the curriculum, rather than retaining the integrated nature of the teaching with disease-based knowledge. As Lloyd and Rosenthal (1992) express in relation to psycho-social knowledge, this is not to say that other knowledge is not available to be learnt, simply that within the allocated time, teaching is focused on areas thought not to be addressed elsewhere.

Many texts make distinctions between the nature of communication in hospital and general practice settings, justifying the delivery of teaching in general practice, in relation to the type of communication taught. One way in which communication is characterised as different is the nature of the *process* of communication:

*"It was also considered that this would **complement history-taking from hospital in-patients**. A patient in the hospital often already has a well defined '**diagnosis**'. So the student tends to go through a mental or written **checklist** and extracts the information appropriate to that '**hypothesis**'; in an initial general practice interview, in contrast, the task will be both to **discover and define the problems**. In this primary **interview style is as important as content**, and a good approach is one in which **information is allowed to emerge from the patient** by using 'open-ended' **interviewing techniques** (Enelow, 1972)" (Armstrong, 1979, p. 82)*

The *process* of communication is treated as knowledge particular to the general practice placement. Hospital communication is associated with hypothesis-testing using pre-defined questions. General practice, in contrast, is associated with exploration and definition of problems with patients, focusing on the use of techniques (such as open-ended questions) and interview style to enable information to emerge from patients during the encounter. Through the separation of knowledge about communication process and content, it becomes possible to locate content and process knowledge in different physical and curricular spaces.

Communication process can be taught as something separate from the embodied nature of communication about a particular disease with a particular patient.

The integration of communication and other knowledge forms in general practice placement clinical encounters is often used in this field as a justification for the provision of teaching about communication in the general practice setting. There is, however, a paradox within this field between the stated intention or expectation to teach communication as an integrated aspect of a general practice clinical encounter, as might be aligned with a discovery gaze, and the production of general practice placements as providing a compartment of knowledge about communication, aligned with a deciphering gaze. This paradox is evident in texts as far back as the 1970s. This paper, for example, makes a distinction between other papers, which separate teaching of interview techniques with diagnostic skills, and its own approach:

> *"[Others] have tended to be similarly* ***concerned with improving interview techniques or diagnostic skills****. The shortcomings of these approaches is that they* ***tend to view these functions in isolation*** *from the* ***more fundamental question of the medical problem****." (Armstrong, 1979, p. 85)*

The separation of teaching about communication, rather than integration, is explicitly commented upon in Armstrong's text, in an attempt to mark itself apart from other texts as teaching communication embedded in clinical consultations:

> *"By focusing on the nature of the patient's problem this teaching tries to place* ***interviewing and diagnostic procedures in their proper context in the doctor-patient relationship****." (Armstrong, 1979, p. 82)*

However, despite attempts to describe placements as communication teaching in clinical encounters, the text goes on to treat general practice placements as providing a compartment of knowledge *not* taught in hospitals and distinct from other clinical knowledge forms. Despite, then, the overall principles stated about the integration of communication teaching in clinical encounters, the stated priorities for teaching, treat communication as a separate and compartmentalised aspect of the curriculum, delivered in the general practice placement. Armstrong, for example, reports that:

*"The students are **informed that the purpose of the interview is to come to an understanding of the patient's problem** and while this may include establishing medical diagnoses, the **interview should be primarily orientated towards the patient' perception and interpretation of symptoms and their social consequences.**" (Armstrong, 1979, p. 83)*

The primary educational purpose of the placement is focused upon the interview process to elicit patient concerns, and eliciting patient experiences, which may or may not include the formulation of a diagnostic disease framework. This produces a paradox between the justification for teaching communication in this setting and the compartmentalised focus of the teaching on communication process.

One frequent way in which this separation of communication and diagnostic knowledge is justified within texts is the delivery of general practice placements about communication *early* in the curriculum. This produces the knowledge to be learnt as *basic*, and limits the existing disease-based diagnostic frameworks to which students can link their encounters, resulting in a primary focus only on the communication process at this stage, rather than integrated teaching about both. In a text about teaching techniques for interviewing skills, for example, this paper states that all patients used for teaching have a physical disease:

*"Each patient has a **physical problem** to present such as angina or a recent coronary." (Kent, 1981, p. 39)*

The integrated nature of the students' learning about disease and communication processes, are however, separated in the reported learning aims of the session:

*"The student … is **reassured that he is not required to deal with any medical problems on this occasion**. He is **asked simply to make the opening moves of what would potentially be a long-term relationship with a new patient**."*
(Kent, 1981, p. 39)

The teaching focus, although offering potential to embed the integrated nature of disease and communication processes, is said to focus on the establishing of a relationship with a patient, and the communication surrounding this process.

The association between general practice placements and communication knowledge as a separate element of the clinical encounter, produces a number of problems in terms of the status of general practice placements and faculty, in relation to hospital placements and teaching staff. Here, for example, is a text which demonstrates the hierarchy produced between hospital and general practice placements, when knowledge is polarised: locating communication in general practice, and disease-based knowledge in the hospital. Knowledge about communication becomes simply 'talking' and 'chatting':

> *"GPs are looked down on as being **hospital drop-outs, just chatting to people**. The hospital was seen by many students as the **real place for students to learn** about medicine with **general practice being seen as a contrast** – **outside** the students' main location.... The **absence of formal assessment for the GP attachment** together with a view that **GP teaching lacks factual knowledge** seemed to **reduce the status of the subject**…'The important people in medicine are doing transplantations and cardiac surgery. **GPs talk to people**.' " (Mattson, 1991, p. 146)*

The characterisation of general practice placements as knowledge about the process of communication is associated with the positioning of general practice placements as inferior knowledge in relation to the factual disease-based knowledge of hospital specialists. The physical location of communication knowledge outside the students' core teaching site produces a sense that this knowledge is an additional extra, in contrast to the core and essential disease-based knowledge taught in hospitals.

Although I have referred to communication as knowledge, texts about communication teaching in general practice placements often use terminology such as 'techniques' and 'skills', making this knowledge distinct from hospital-based or text-book knowledge. Through use of this terminology, knowledge about the communication *process*, becomes treated as a basic procedure, in contrast to the knowledge required to deal with communication *content* and diagnostics. This terminology is used consistently across the field. Here is an example from the 1970s:

> *"In this paper a relatively simple yet apparently **successful technique** for allowing students to develop some understanding and expertise in **basic patient communication** is described." (Armstrong, 1979, p. 83)*

This focus on the communication process produces emotional exchange, such as empathy, between student and patient as a technical skill that can be taught to students. Here are two examples of papers that treat empathy, taught within general practice placements, as a technical skill. Irwin, for example, attempts to separate in his analysis, communication skills used in routine social interaction, from those requiring students to learn a specific knowledge base. With regard to empathy, he states that:

> *"The present study appears to confirm that **interpersonal, empathic communication can be learned** (Engler 1981); and that **certain of the skills which go to make up this communication** require the acquisition of new **emotional styles**." (Irwin, 1984, p. 95)*

Through its characterisation as a technical skill and style, communication becomes something explicit and teachable within the context of a communication course in the general practice setting. A similar position is maintained some 20 years later in this paper from QMUL describing the delivery of a communication special study module in a general practice placement:

> *"...one student was interested in exploring the area of **demonstrating empathy**.... [this student] had concerns about interviewing patients who may become distressed whilst she was talking with them and how she should best deal with this. Sessions using **simulated patients** enabled students to put into **practice techniques** they had seen or read about... This student engaged in a scenario that was developed to encourage her to **respond appropriately** to a patient who was distressed after receiving bad news." (Nicholson, 2003, p. 46)*

General practice placements are characterised here as the teaching of specific techniques to help students demonstrate empathy and manage their emotional distress in response to patient's stories, in a professionally 'appropriate' way. Similar teaching of techniques are also described in this paper to establish control within an interview and manage 'garrulous' patients (Nicholson, 2003, pp. 46-47). The reduction of communication knowledge in general practice placements to a set of procedures or skills is problematic in terms of the hierarchical treatment of this knowledge in relation to hospital, disease-based knowledge content.

In summary, many papers set out a rationale for teaching communication in the general practice setting in relation to the integrated nature of communication and disease

management in this setting. The papers, however, often go on to characterise general practice placements as focusing teaching specifically about communication knowledge. Many papers make distinctions between the hospital and general practice placement in relation to communication knowledge. Communication process and content are separated, allocating the teaching of particular communication processes to the general practice setting. These are contrasted with the application of a standard pre-defined, disease-framework in the hospital setting. As a compartment of the curriculum, general practice placement teaching of communication is characterised as a technique or skill, which is basic and taught early in the curriculum. This produces student emotion, such as empathy for patients, as basic learnable processes of technique and style, in contrast to more 'advanced' disease-based knowledge in the hospital setting.

Subject as 'not knowing'

In Chapter 3, I examined the subject position of 'facilitator of learning' made available to the GP teacher. In this chapter, various subject positions are made available through the characterisation of placements through a deciphering gaze. For example, a position as 'learner of curricular component' is made available for the student, rather than 'participatory learner' in professional practice, focusing on particular defined aspects of knowledge, rather than more general participation in workplace-based learning. For the patient, positions are made available as subject with particular features such as 'disease', legitimising the pre-selection of patients for involvement in teaching, previously known by the GP to have a particular condition, or even simulated patient for teaching.

For the GP, available subject positions within the texts contrast markedly from those made available through a gaze of discovery. Focusing upon a particular knowledge compartment makes the 'work' of the GP as clinician and teacher distinct, rather than integrated. The knowledge of the GP is not made visible in its entirety, but compartmentalised, producing the GP as teacher of 'basic' knowledge' or 'knowledge not taught in the hospital'. As a teacher, for example, of communication, the GP's knowledge about disease remains invisible and thereby not known within the texts. A GP is also produced as 'not knowing' through their use of facilitation teaching techniques. In Chapter 3, the legitimation of experiential knowledge and student-patient interaction made available a legitimate position for the GP as facilitator of the students' learning. Through a gaze of deciphering, a contrasting position is produced for the GP teacher as using facilitatory techniques to teach because of lack of knowledge or 'not knowing'. In this text, for example, the GP's use of facilitation is said to be used to address their lack of 'up to date' knowledge, here teaching evidence-based medicine:

"…teaching is increasingly being undertaken by team members and not just by individual GPs…. Another change in undergraduate teaching has been the ***move away from didactic teaching*** *towards self-directed learning. Some of the driving forces behind this have been the* ***rapid advances and changes in medicine****,* ***making it difficult to keep up to date****….Problem-based learning, with students learning how to confront problems without the solutions, learning how to find the answers and then receiving feedback,* ***has been suggested as one solution*** *(Sackett, 1997)." (Hagdrup, 1999, p. 490)*

In summary, a different range of subject positions is made available for students, patients and GPs, when placements are characterised in texts through a gaze of deciphering. Through focus upon curricular compartments of knowledge, positions associated with practice and teaching, become separated. Students are offered positions as learner of curricular component, rather than participatory learner in professional practice. Patients are offered positions as subject with pre-selected component of knowledge. The work of the GP is made invisible or only partially visible within texts, producing separate positions for them as teacher or clinician, and a subject position as 'not knowing' or subject with basic knowledge. This produces imbalances in power-knowledge relations between teachers in the hospital and general practice space.

Pedagogic logic: compartmentalised and pre-determined

Within this chapter, I have shown how many of the ways in which general practice placements are characterised through a deciphering gaze, as compartments of knowledge distinct from hospital placements, produce a paradox. Whereas the delivery of teaching in the general practice space is often justified within texts as providing integrated knowledge in a clinical context, the way in which placements are characterised in texts is often as specific or pre-defined compartments of knowledge. I have shown how characterisation of general practice placements as, for example, disease or interactional categories of knowledge, are often justified in terms of the embedded integration of these conditions in patient encounters (as described in Chapter 3 in relation to a gaze of discovery). General practice placements, however, are often subsequently characterised as teaching *only* about one specific compartment of knowledge. This allocation of different categories of knowledge to different curricula and physical spaces (like the treatment examined elsewhere in Chapter 5 of general practice placements as innovative, in contrast to established hospital placements) produces hierarchical relations in texts between general practice and hospital placements.

Texts characterising general practice placements through a deciphering gaze use or claim to inform development of a pedagogic framework, which compartmentalises or pre-determines what is said to be taught and learnt in placements. While this particular pedagogic logic is not specific to texts about general practice placements, and is commonly found elsewhere in texts about medical education, it produces a conceptual tension relevant to general practice placements, between the delivery of teaching and service in the general practice space. In this section, I examine how the characterisation of general practice placements through a deciphering gaze aligns with this particular pedagogic system, often treated as desirable and modern. I then discuss the problems this produces for the integration of teaching and clinical practice in the general practice setting. This dominant way in which learning is treated as desirable concerns both preparation and structure of learning:

> *"Recent **modernisation** of the undergraduate medical curriculum has highlighted the need for more **planned, as opposed to ad hoc or opportunistic** teaching (Schuwirth, 2006), with particular importance placed on **preparation and structure** (Dearing, 1997; GMC, 2002)....."*
> *(Bryant, 2008, p. 45)*

Good learning is treated as alignment with curricula, planning and structuring learning in advance to meet pre-determined outcomes. This contrasts with the ad hoc and opportunistic nature of much workplace-based learning in generalist clinics, where teaching through problem-solving by professional and student responds to patients' needs, and involves processes and content unknown prior to the teaching session. Learning in a generalist workplace becomes, within this deciphering gaze, treated as haphazard and unreliable:

> *"**Curriculum objectives or outcomes** have been devised by many medical schools to ensure that students achieve core knowledge and skills by the time they qualify (Dacre, 1996). However, even when students and teachers are aware of the learning objectives, they can **experience difficulties in meeting them**. This is **a particular problem in clinical settings** where students' exposure to the range of clinical experiences necessary to meet objectives is very **variable**. Learning has been described as **unstructured** and **haphazard** in that **learning experiences vary**, even among students undertaking clerkships in the same clinical department (van der Hem-Strokroos, 2001)."*
> *(Smith, 2006, p. 884)*

If what is thinkable as good learning is achievement of curricula objectives and outcomes that align with pre-determined curricula, the value of general practice placements becomes problematic and challenging. Here, for example, is a section taken from Mattson et al.'s discussion of their student interview data about general practice teaching highlighting the problematic nature of general practice placements within this conceptual framework for learning, especially in view of the short time periods allocated to general practice teaching:

> *"There is a need, too, for **clearer aims** related to, and with **more consistent**, teaching otherwise the very **generality of general practice seems only to confuse some students** within what is still a relatively **brief and intermittent practical exposure**." (Mattson, 1991, p. 148)*

What is valued as good learning here is consistency and consensus of student experience across placements. The absence of a pre-determined focus for learning is treated as confusing or over-whelming for students, particularly due to the short-term nature of placements.

This pedagogic framework prioritising pre-determined allocation of knowledge makes it thinkable to allocate teaching to *either* hospital or general practice placements, rather than tolerating commonalities of teaching across both settings. This text, for example, is taken from the CeMENT study comparing the delivery of internal medicine teaching across general practice and hospital sites. This text sets out to examine the commonalities of teaching across general practice and hospital sites. It acknowledges that some knowledge is *only* available in the hospital setting. Rather, however, than positioning the sites as largely equivalent (with noted exceptions), the text goes on to describe 'balance' as provision of teaching in general practice which fills the gaps 'ill-served' by the established hospital curriculum, or the 'added value' (Walters, 2007, p. 101) of general practice-based teaching:

> *"...students and faculty perceive community-based teaching to have **specific educational advantages**, such as the opportunity to **gain experience of common conditions** (Foldevi, 1993; Satran, 1993) and a **high level of supervision** (WFME, 1994a). However, certain educational experiences are **only available to students on the hospital** ward (Grum, 1995). One task facing medical educators is to **achieve a balance** between hospital and community sites. Advocates of community-based teaching have suggested it might have*

advantages in the ... key areas which are considered ***ill-served by a traditional curriculum*** *(Whitehouse, 1997, pp. 3-18)." (O'Sullivan, 2000, pp. 648-9)*

If a pedagogic system treats general practice placements as about basic and early preparation for hospital placements, or 'filling the gaps' in a hospital-based medical education, then the relevance and value of the generalist's professional work becomes questionable. Despite the generalist and integrated nature of patient care being used to justify the characterisation of general practice placements, what is produced through a gaze of deciphering are components and categories of knowledge that are dissonant to everyday clinical practice. This positions general practice placements as supplementing what is provided by hospital teaching, rather than sharing with undergraduates the work of a GP:

"In many medical schools teaching in general practice is mainly concerned with the observation ... of the ***normal work of the general practitioner****.... The teacher may have* ***sufficient clinical material*** *but* ***insufficient time*** *in which fully to discuss and debate the problems presented by the patient. Alternatively,* ***too many patients may be seen with similar complaints****.... To allow the student to see the* ***normal spectrum of work*** *and the life of the general practitioner is important, but if it is the sole method of allowing the student an* ***experience of medicine outside the hospital****, it appears to be more appropriate to the vocational trainee than it is to the undergraduate. If the aim of the teaching course is to* ***fill the gaps*** *in the general medical education of the student* ***left by the purely hospital-based curriculum****, the teaching course is almost of* ***more importance for those who will continue in a hospital career than it is for those who will become general practitioners****."*
(Barber, 1973, pp. 170-1)

Characterised through a deciphering gaze, general practice placements are treated as preparation of an undergraduate medical student to fulfil completion of curricula outcomes and assessments, and supplementation of areas poorly covered in hospital teaching. Any relation between student learning and professional practice in general practice, become positioned as of greater relevance to postgraduate trainees planning to become GPs.

Characterised as compartments of knowledge relevant to a pre-defined curriculum, general practice becomes polarised, rather than integrated, as a space for undergraduate teaching and clinical service. This polarisation positions teaching and clinical service in competition as

separate activities, rather than co-existent. When GPs' workload becomes described as over-burdened, this makes thinkable a tension between the two activities, reducing teaching to an additional extra, rather than core business. This is exemplified in this next text, reporting a questionnaire survey of GP teachers for a medical school in Leicester:

> *"There is evidence on a national scale that 'general practice is not only becoming **busier** but the people seen are more **severely ill** than a decade ago.' (BMA, 1994). It is clear [from our survey] that several teaching practices have **experienced great difficulty** in accommodating such an increase in clinical service load, while at the same time maintaining the quality of undergraduate clinical teaching. Understandably, many practices have opted to maintain the level of clinical services at the expense of student teaching, whereas others have **struggled** under increasing pressures to deliver both. In the face of this expanding workload and our finding that 88% of respondents feel that **remuneration for teaching is inadequate**, it is not surprising that there is a **reluctance to expand teaching activities at current levels of support**."*
> *(Wilson, 1996, p. 459)*

Through a gaze of deciphering, the purpose of teaching is not for the student to share in the professional clinical experiences of GPs, but rather to fulfil curricula aims. If curricular and clinical knowledge are conceptually separated, the professional duties of GPs to fulfil curricula pre-determined outcomes, and address the clinical needs of patients also become distinct. It then becomes possible to position teaching and service in a hierarchy of value. Within a monetary logic of value, service is much more valuable than teaching, thus threatening the sustainability of teaching in the general practice setting.

In summary, I have examined how the dominance within texts of a pedagogic framework, which values standardisation and pre-determination of learning, is problematic for general practice placements. This framework lies in tension with the variable and unpredictable nature of generalist professional practice. It also favours compartmentalisation of knowledge and hospital-based organisation of knowledge, producing general practice placements as supplementary to hospital-based learning, filling in the gaps in the curriculum. This produces hierarchical relations between general practice and hospital placements and the polarised knowledge located to each. It also produces a conceptual division between the work of the GP as a teacher and clinician, separating the undergraduate students' learning from

professional practice and producing a hierarchical dyad in the value of the GP's work as teacher and clinical service provider.

Conclusion

In this chapter I have examined how knowledge about disease is compartmentalised as distinct from that taught in hospital, being chronic, multi-morbidity, or basic specialised teaching. Ways of splitting knowledge (see Table 2) are used to, for example, locate psycho-social teaching (using a Cartesian mind-body division) or attitudinal change (dividing knowledge, attitudes and skills teaching) to general practice placements. This produces a tension between what is defined by the curriculum as relevant to learn and routine, clinical general practice. Routinely presenting patients become treated as irrelevant or a disruption to teaching, and only selected, pre-invited patients with specific conditions of relevance for the students' attention. This compartmentalisation of knowledge also supports a strategy of supplementation, characterising general practice placements as filling the gaps in a hospital-based curriculum. While many texts justify teaching in general practice as integrated patient encounters, placements are often paradoxically characterised through a deciphering gaze, separating components of knowledge, compartmentalising patients and separating the work of a GP as teacher or clinician.

In the next chapter, I will examine how research is justified. I will then discuss how the compartmentalised and pre-determined nature of placement knowledge, through a deciphering gaze, aligns with dominant ways in which research is justified and the research subject position produced using pre-determined rules to legitimise the research process.

<table>
<tr><th>Object: general practice placements characterised as…</th><th>Subject positions produced</th><th>Concepts or Logics</th></tr>
<tr><td rowspan="2">Learning about disease:
a) Long-term or Chronic
b) Prevention or minimising complications
c) Multi-morbidity or multiple co-existing diseases
d) ‘basic’ specific disease condition</td><td>Patient (often pre-selected) as subject with disease</td><td rowspan="8">• Learning curricular component
• Filling gaps in hospital-based curriculum
• Pre-determined, curriculum defined, compartmentalised, structured, consensus teaching, standardisation.</td></tr>
<tr><td>GP as subject who knows only about e.g. basic, chronic or preventative knowledge compartment. Contrasting with hospital doctor as subject who knows about severe, acute and curable disease</td></tr>
<tr><td>Learning about psychosocial knowledge</td><td>Patient as only psychosocial component</td></tr>
<tr><td rowspan="3">Learning about communication knowledge</td><td>Student as subject who learns a curriculum component</td></tr>
<tr><td>GP as subject who only knows curriculum component (e.g. chatting to people; basic / early knowledge)</td></tr>
<tr><td>Hospital doctor as subject who knows everything except gaps filled by general practice teaching</td></tr>
<tr><td rowspan="2">Learning about attitudes</td><td>Patient as subject who is normal (if the same as or familiar with a student)</td></tr>
<tr><td>Student as subject who is ‘normal’ (and the same as a patient) when well and functioning independently and ‘abnormal’ if unwell</td></tr>
<tr><td></td><td>GP as subject ‘not knowing’</td></tr>
<tr><td></td><td>GP as teacher or clinician</td><td>Service and teaching as discrete / not integrated</td></tr>
</table>

Table 2: Summary of Analytical Categories for a 'Gaze of Deciphering'

Chapter 5: How is doing research within this discursive field justified?

Introduction

This chapter examines how research within this discursive field is justified. One aspect of Foucauldian Discourse Analysis (FDA) is to examine the rules which establish the conceptual or logical relations used between statements (Howarth, 2000, p. 53). These rules govern whether or not classes of statements are acceptable or excluded from a discursive practice (Howarth, 2000, p. 53). A second aspect is to examine the strategies or meta-rules determining how particular objects, subject positions and concepts have been used (and not others), and the power relations produced within the texts. One important aspect of this thesis is to understand how the justifications for research within this field relate to the ways in which general practice placements are characterised. How is it thinkable to justify research; how is it thinkable to characterise general practice placements; and how do these relate? Chapters 3 and 4, examine how general practice placements are characterised. This chapter is dedicated to the examination of justifications of research. I consider in Chapter 6, how the ways in which research is justified relate to the characterisation of general practice placements and the overall strategies these produce.

To examine how research is justified within this field, I approached the texts in a variety of ways. I wanted to understand how texts are made legitimate as *research* texts. One approach I used was to examine how the texts made claims about the significance, rationale or contribution of the published work. This included, for example, how research was framed as a solution to a particular problem. Another approach was to examine the ways in which claims about the text as 'research' were supported. This enabled me to examine how certain logics or arguments are used as thinkable ways of justifying production or existence of research. It also enabled me to examine how certain ways of doing research and being a researcher are made thinkable, and others not. This chapter examines, then, both what is made thinkable (and unthinkable) as a legitimate claim for the production or existence of research, and how particular subject positions are made available in relation to the justifications of research.

To select the texts for this thesis, I kept inclusion as wide as possible, defining a 'research paper' as one that had at least a sentence describing a method. There were, therefore, a

broad range of texts – some which focused more on the research process, and others predominantly reporting teaching. These latter papers, in particular, helped to develop my analysis for this chapter, enabling me to examine the distinctions between teaching and research within a text. I found particular sections of papers helpful to address different aspects of the analysis. When examining how a text claimed the significance, rationale or justification for the existence of the research, I found the introductory and discussion sections most helpful. When examining ways in which claims were made to justify the text as research, I found the methods section most helpful. This chapter is broadly divided into two categories examining the justification of research as 'evaluation' and/ or as 'making voices heard'. I then examine the subject positions made available within these texts to the researcher, categorising these researcher subject positions as 'evaluator' and/or as 'making voices heard'.

Evaluation

The dominant way in which research is justified in this field is as an evaluation. This is done through positioning general practice placements, or teaching methods in the general practice setting, as an intervention to be evaluated. The research is usually justified as an evaluation, through positioning the placement, teaching method, or nature of the research participant in the study as an *innovation*. The logic of innovation is used to justify the evaluation of placements, or re-invention of placements as the setting for an innovative teaching method. One common logic drawn upon to support the existence or re-invention of general practice placements is GMC policy. A further logic that research informs practice, underpins claims that research is required to evaluate practice.

Evaluation of general practice placements

Research is often justified as an evaluation of general practice placements. This, for example, positions the placement as an intervention and the research as an assessment of its effectiveness. A logic of innovation is drawn upon to position the placement as new, or a re-invention of general practice placements, in order to justify the research as an evaluation:

> *"The first year experience of an **innovative experiment** in undergraduate medical education is described. The study **investigated the educational effectiveness** of prolonged clinical attachments for medical undergraduates in community hospital-based **general practice**." (Grant, 1997, p. 364)*

The treatment of placements as innovative and experimental justifies the research as a way of establishing their effectiveness and thereby contributing to debate about their value. In more recent papers, elements of the general practice placement organisation or teaching, are presented as a new development, in order to re-position the placements as innovative and thereby worthy of evaluation. The position of the general practice placement as innovative is often made in contrast to established or traditional hospital-based placements. This paper, entitled 'an evaluation of an innovative, centralised system' positions an element of the organisation of the placement: giving feedback to tutors, as an innovative intervention and thereby justifies the research:

> *"A variety **of community-based medical undergraduate** modules have been developed over the last six years that **complement more traditional hospital teaching**. To monitor and enhance the quality of this teaching, a system was designed that regularly and accurately fed back student evaluation to the general practice tutors. **An evaluation of the effectiveness of this system was undertaken**…" (Nicholson, 2003, p. 184)*

In summary, while the treatment of general practice placements as innovation justifies the production of research, it simultaneously treats placements as un-established and temporary. The positioning of general practice placements in comparison to hospital-based teaching, produces a dyadic polarisation, treating hospital-based teaching as established and traditional, in contrast to general practice teaching as new and un-established.

How GMC policy is used to justify research

One common way in which the evaluation of general practice placements, and their positioning as innovative, is achieved is in relation to the logic of GMC policy. GMC policy is used in two ways to justify research about general practice placements. In this section, I firstly examine how GMC policy is used to support the existence of placements. This is evident, in particular, in early published texts which draw upon GMC policy to support the description of a placement initiation, before presenting an evaluation of the programme. A second way in which GMC policy is used is to support a re-invention of placements to address policy requirements, such as patient-based learning or greater community-based teaching. GMC policy is used, therefore, to make thinkable and even normalise the provision of general practice placements. However, while the policy provides a strong logic to support the existence of a general practice placement, it also reinforces the placement as a policy-

driven innovation and thereby un-established in relation to existing hospital-based teaching. I will now demonstrate these categories.

Policy supporting the invention of general practice placements

GMC policy is used across the texts to justify the existence of general practice placements and their subsequent evaluation. The provision of teaching in the general practice setting is positioned as a fulfilment of GMC policy requirements. The research is then justified as evaluating the policy-driven innovation. Here, for example, is a text from the 1970s, which draws upon GMC policy to support the initiation of general practice teaching:

> *"In the last six years the number of medical schools in Great Britain in which all undergraduates are given teaching in general practice has risen from eight in 1966 (Pearson, 1968) to 22 in 1972 (Byrne, 1973) and is approaching the recommendation made in 1967 by the* ***General Medical Council*** *that: 'All medical schools should have "****growing points****" for the undergraduate teaching of general practice." (Barber, 1973, p. 165)*

GMC recommendations to promote the expansion of general practice teaching are used to justify this research as important and relevant. The rise in numbers of medical schools teaching general practice is used to emphasise the relevance of research about placements, prior to the author presenting his own evaluation of an innovative general practice placement at Glasgow medical school.

Policy supporting the re-invention of general practice placements

In more recent years, particularly after the publication of 'Tomorrow's Doctors' 1993, GMC policy has been used to support the existence of general practice placements. There is a shift, however, from supporting their initiation, to re-invention. General practice placements thereby become re-characterised as new policy-driven learning, reinforcing the position of the placement as an innovation. The logic of GMC policy is often used to support the position of general practice placements in relation to existing hospital-based teaching arrangements. This next text, for example, sets out to empirically test and compare the provision of teaching across hospital and general practice settings, following 'Tomorrow's Doctors' policy recommendations:

> *"In 1993 the* ***GMC published Tomorrow's Doctors****, outlining ways in which future generations of medical students might be taught most* ***appropriately***

(GMC, 1993b). Two key themes were ***early exposure to clinical skills*** *and* ***increased use of non-hospital sites****, such as* ***general practice (GP) surgeries for teaching****.* ***In its response to Tomorrows' Doctors,*** *the medical school…. introduced … a new,* ***systems-based curriculum****… As part of this…* ***students would be taught the basic clinical skills of history taking and physical examination, in GP surgeries as well as in hospitals.****"*
(Johnston, 2000, p. 692)

Although published seven years after the publication of 'Tomorrow's Doctors', this text draws upon the logic of GMC policy to explain the rationale for this research, which aims to empirically compare teaching in the general practice and hospital settings. A logic that evidence informs practice is used to position the research as a way of establishing the effectiveness of this innovation, compared to hospital-based teaching. The text goes on to demonstrate the equivalence of clinical skills teaching in both general practice and the 'gold standard' hospital site.

Policy logic is used to justify the existence of placements and their evaluation in texts, serving a dichotomous purpose to both support, but also threaten the placement's existence. Here, for example, is a text published in 1996 after the publication of 'Tomorrow's Doctors' and early efforts to implement policy changes. General practice is positioned as an innovation to address GMC requirements to promote early and continued patient contact:

"Medical schools are increasingly being asked to ***question the validity of teaching hospitals*** *as educational bases for teaching medical students (Genn, 1986)…. Recent guidance from the* ***General Medical Council criticised*** *the factual overloading of students and paucity of early and continuing contact with patients (GMC, 1993b). General practice, '****the new boy'*** *to the medical faculty is gradually emerging as a valuable teaching area with useful clinical skills and settings to offer (Preston-White, 1988)." (Mowat, 1996, p. 304)*

GMC policy is used to support the existence of general practice placements in contrast to hospital-based teaching. The general practice placement has been re-invented as early patient-based teaching, to address policy recommendations. This produces general practice placements not as something long-established or traditional, but as 'the new boy' with only emerging credibility as a valuable teaching site. The research is positioned as a way of informing practice, evaluating if these innovative placements are able or not to fulfil these

policy requirements. The policy provides a useful justification for the existence of these placements, but simultaneously positions placements as new and un-established and thereby worthy of evaluation:

> *"In medical school evolutionary terms their [patient contact courses]* ***introduction has been a rapid process, and the effects are only beginning to be evaluated*** *(Cade, 1993). This study sets out to explore…. The types of early patient contact course offered by Departments of General Practice in the pre-clinical years…" (Mowat, 1996, p. 304)*

In summary, the existence of research is justified as evaluating general practice placements. A logic of GMC policy is used to support the existence of general practice placements. In one way, this provides a strong rationale for developing and maintaining placements, and justifies the existence of research, which evaluates and helps inform and develop these teaching innovations. In another way, however, the use of GMC policy within these texts serves to re-invent placements as innovation to meet policy recommendations. The use of GMC policy to justify the existence of the research, and need for evaluation to establish placement effectiveness, then reinforces the position of placements as new and un-established in relation to hospital-based teaching. These justifications also draw upon a logic that research informs practice, to position the research as a necessary way to establish what is happening and changes needed in practice.

Re-inventing general practice placements as an innovative space for learning

In this section, I examine how some research is justified as an evaluation of the innovative delivery of teaching methods within general practice placements. It is, therefore, not only the general practice space that is treated as new, but also the way in which teaching is delivered or teaching techniques used within this space. This reinforces an association between the general practice placement and new or modern teaching approaches. This conceptual alignment, re-invents the general practice space as a new discovery for the provision of learning. General practice becomes positioned as a new, desirable, teaching site within a discourse emphasising the huge numbers of medical students requiring clinical placements and the university as constantly looking for places to educate. Research is then justified as reporting on and evaluating the use of new teaching methods in this space:

*"The **innovation of new methods of teaching** and **their subsequent evaluation** are now major **educational priorities** (Parlett, 1972)."*
(Murray, 1978, pp. 6-8)

A variety of ways are used within this field to construct general practice placements as involving different knowledge (often in contrast to hospital-based teaching), and thereby requiring different and new teaching methods. These include treating general practice placements as variable, challenging fulfilment of standardised learning objectives, and involving application of knowledge to real-life situations. Rather than characterising general practice placements in this way and researching the placement itself, the research is justified as an evaluation of the associated teaching method. The placement is thereby re-invented as innovative through the provision of a modern or new teaching approach in this setting.

Re-inventing general practice placements as delivery of student-determined learning objectives

One way in which general practice placements are characterised is as providing 'variable clinical exposure'. The placement itself is not evaluated. Rather, student-determined learning objectives (SDLOs) are positioned as an appropriate teaching method. This teaching innovation in the general practice setting is then evaluated. The objective for a research text evaluating SDLOs in the general practice setting states:

*"This study aimed to **assess whether students can use this method** [SDLO] to meet **widely differing learning needs within the general practice clerkship**."*
(Smith, 2006, p. 884)

The nature of learning in the general practice placement is treated as different to other placements, justifying the use of alternative, new teaching methods and their evaluation in this study. The rationale for the use of student-directed learning objectives as a teaching method in general practice placements is provided in the introduction of the paper. This constructs general practice placements as problematic in terms of using usual teaching methods and learning objective setting, providing a rationale for evaluation of an alternative teaching method:

*"In clinical clerkships**, student learning is often unstructured and diverse**. Even when curriculum objectives are explicit, they are seldom used by students to guide their learning. **Student-determined learning objectives** may help*

students to structure their learning… Even when students and teachers are aware of the learning objectives, they can experience difficulties in meeting them. This is a ***particular problem*** *in clinical settings where students'* ***exposure to the range of clinical experiences*** *necessary to meet objectives is very* ***variable****." (Smith, 2006, p. 884)*

General practice placements are characterised as 'unstructured', ' diverse' and 'variable' challenging students' fulfilment of usual curriculum objectives. Student-directed learning objectives are positioned as a new teaching method, better aligned with these characteristics of placements. The research is then justified as an evaluation of this teaching innovation in this setting.

Re-inventing general practice placements as delivery of computer-assisted learning

A second way in which general practice placements are re-invented as innovative is through the evaluation of computer-assisted teaching methods in this setting:

*"****Computer-assisted learning (CAL****) has* ***been introduced as part of the undergraduate teaching course in general practice****… " (Murray, 1978, p. 6)*

The research is then justified in relation to the evaluation of the use of this teaching method in this setting. General practice placements are characterised in particular ways to justify their alignment with new Computer-assisted learning (CAL) teaching methods. Placements are said to involve different knowledge, characterising learning as preparation for professional practice. This is made in contrast to hospital-based teaching and text-book learning, characterised as preparation for exams and acquisition of associated knowledge:

"The design of the programme made [the students] think, and forced them into conclusions so that they learned in a way which is ***much less possible from a text book*** *or a [hospital] clinic... the students felt that the case histories* ***brought together a variety of different disciplines*** *as seen from the general practice view point. ...The* ***undergraduate curriculum at present is concerned with the acquisition of knowledge whereas the work of a doctor is concerned with applying this knowledge to a 'real-life' situation****. CAL is an attempt to compress this period and give the student an opportunity of* ***applying this knowledge to a 'real-life' situation****." (Murray, 1978, pp. 6-8)*

General practice placements are positioned as distinct from others, involving application of knowledge and a variety of disciplinary perspectives. Computer-assisted learning (CAL) is positioned as a modern teaching method appropriate for applied, clinical, professional learning, in contrast with existing textbook methods or hospital teaching clinics. General practice placements are, therefore, characterised as workplace-based learning. However, the placement is not directly evaluated. The teaching space is re-invented in relation to the use of CAL teaching methods, and the research justified as an evaluation of this new teaching method in this setting.

In summary, some texts justify research as evaluation of placements, treating them as an innovative intervention. Other texts re-invent placements as innovative through evaluation of modern or new teaching methods in this setting. General practice is, for example, characterised as variable in relation to the justification of evaluation of student-determined learning objectives in this setting. Similarly, placements are characterised as preparation for professional practice and application of knowledge to particular cases, in relation to the evaluation of computer-assisted learning in general practice placements. These texts focus, then, upon an innovative element of placements or innovative component of teaching, rather than justifying research directly as evaluation of placements as workplace-based learning.

Hearing Voices

A second way in which research is justified in this field is hearing voices: bringing new voices into the field of research about general practice-based medical education. This is achieved through the production of new research participant 'perceptions'. The research in this category is justified specifically in relation to the production of particular voices and bringing these into medical education research. Research is justified as producing or hearing voices, such as patient preferences in relation to participation in general practice placements; bringing in previously unheard staff member's preferences about participation in general practice placements; and justification of research as production of expert voices in relation to organisation of general practice placements.

Bringing in unheard voices

The first category in this section examines the justification of research as producing knowledge about patient preferences in relation to their participation in general practice placements. One way in which this is done is through making a distinction between what is knowable about a social group in practice, in contrast to what is knowable through their treatment as research participants. This, for example, makes patients knowable as research

participants in a different way, as distinct from knowledge produced with patients in practice. Some more recent texts make claims about the newness of research using patients as research participants, but in fact this justification is also evident in early texts. I have chosen a text from the 1970s to illustrate this category. In this paper entitled 'Patients' Attitudes to Medical Students in General Practice', the author's stated objectives for the study include:

> *"To devise a **feasible method by which a practitioner** could **assess the attitude of his patients** to the presence of students at consultation."*
> *(Wright, 1974, p. 372)*

Research is justified here as the application of a method by the practitioner, in order to produce knowledge about the attitudes of his patients regarding involvement in teaching. A contrast is drawn within the text between the author's reports of the patients' actions during sessions he had previously taught – only 3 patients having asked to see a doctor without a student – and the preferences articulated by patients as research participants. This distinction between practice and research treats what is knowable about this social group as different when the subject is treated as a research participant. This claim is justified through description of particular methodological rules by the author, in order to produce research participants. Wright describes conducting standardised 6-7 minute interviews to explore patient attitudes to the presence of medical students in his practice:

> *"**259 consecutive** adult patients were **interviewed** regarding their attitudes to the presence of medical students at consultation, at examination, and at home visits. **Few patients declared reluctance** to discussing physical illness and smoking or drinking problems **in the student's presence**, but many had appreciable inhibitions about discussing almost every other common component of consultation. **Over half of the younger women interviewed would prefer students not to be present** at physical or pelvic examination.... **in this study 185 patients had previously consulted their doctor when a student was present....: yet only three ... confessed to ever having asked the doctor to see him alone**." (Wright, 1974, p. 372)*

The justification and rationale for this research is that it has produced previously unknown knowledge about patient preferences for participating in teaching encounters. The application of a standardised interview and production of patients as research participants is said to make visible a number of reported 'inhibitions'. This produces knowledge about the

conditional nature of acceptability to a student being present: dependent, for example, upon the type of presenting complaint and gender of the patient. This is then contrasted with the author's experiences as a practitioner and the low numbers of patients refusing a student to be present during their consultation.

Patients and students are the most common unheard voices, which the research is justified as making knowable, through their production as research participants. There are, however, other social groups who have been categorised in this way, justifying the research as drawing attention to a particular set of concerns or issues, previously unheard or unacknowledged. To illustrate this category, I have chosen a text that justifies the research as making visible the previously unacknowledged role of practice staff in decision-making about participation in teaching. The text treats practice staff as new research participants, making a distinction between what is already known through treatment of GPs and patients as research participants, and this study that explores the impact of teaching on the practice team or 'non-GP practice members' who are positioned as currently 'less involved in the decision' (Quince, 2007, p. 598):

> *"The impact of such teaching on students, GP tutors and patients is becoming understood but **few studies have examined the impact on the wider practice team**." (Quince, 2007, p. 593)*

Production of the wider practice team as research participants is positioned as a new perspective, giving legitimacy to previously unconsidered issues through their production in the research text. In this text, entitled 'the practices' story', the paper explores the costs and benefits of teaching from the perspectives of practice receptionist and administrative staff. The purpose of the research is claimed in relation to the production of knowledge through the treatment of practice staff as participants. This makes legitimate a range of concerns about the impact of teaching on practice staff and the importance of considering these when deciding about participation in teaching:

> *"Some **practice members, receptionists in particular**, **reported experiencing** costs in the form of added complexity and stress in their job as a result of a decision to which they did not feel party." (Quince, 2007, p. 594)*

The justification of the research as producing new research participants and the related purpose of making visible the perspectives and concerns of this group, enable the authors to

make recommendations, based upon their results. The production of practice staff as research participants is said, for example, to make visible the additional workload implicated in a teaching organisation:

> *"Expanded undergraduate teaching is both feasible and acceptable* ***from the perspective of most practice members*** *but care is needed in organising change to meet the needs of all practice members." (Quince, 2007, p. 594)*

The consideration of practice staff perspectives is legitimised as having produced new insights important to informing the production of recommendations for action to address involvement of these staff in future decision-making.

Hearing existing voices: experts as research participants

A second category of hearing voices again justifies research as producing a social group as research participants in order to hear their voices. In the previous category, a claim is made that the knowledge produced during research was previously unknown. In this category, the voices are treated as known in practice, but are claimed to be previously unheard in research. The treatment of existing voices as research participants, enables particular claims to be made about the value and relevance of the knowledge produced. I have chosen a text to illustrate this category, which uses the production of experts as research participants to increase the credibility of a set of national criteria developed by stakeholders:

> *"…****detailed criteria*** *for undergraduate teaching in general practice are currently* ***determined and implemented locally, without national or regional coordination****.…The aim of this study was to* ***develop a set of core quality criteria*** *for teaching in general practice in the UK with* ***evidence of acceptability to stakeholders*** *in undergraduate and postgraduate education." (Cotton, 2009, p. 144)*

The production of stakeholder experts as research participants is used to make explicit the development of a set of criteria through use of a Delphi methodology, and also to 'evidence' their acceptability. The development of these criteria, are positioned as a way to address a current gap in the existence of national or regional criteria for teaching. This research is framed as the production of a robust solution to the problem of an absence of national criteria. The justification of this research is thereby positioned within a logic of consensus and standardisation, supporting greater commonality and consistency across placements.

Faculty experts are positioned within this text as a new research participant group, providing a basis for recommendations based on production of expert consensus through the research process. A Delphi methodology is described, producing experts and stakeholders as research participants. The authors report several stages to this process:

> *"Criteria for practice-based teaching were **developed at a workshop** at a national conference. An **online Delphi questionnaire** invited educationalists to label these criteria as 'essential', 'desirable' or 'unnecessary' for 'occasional', 'intensive' and 'foundation year' training. Two rounds of the Delphi were completed. . The **views** about the criteria of a range of **stakeholders** … were explored using **focus groups and telephone interviews.**"*
> *(Cotton, 2009, pp. 143-4)*

Each expert is treated as a research participant through the description of a number of different methodological processes. The text also describes the selection of research participants from a wide range of 20 medical schools, to position them as representative of a wider group. The 'views' of participants then become valued, not only in terms of their expertise and experience, but as a selected participant within the research process. The study concludes:

> *"To the best of our knowledge this is **the first nationally derived list of criteria**, capable of being used in both undergraduate and postgraduate practice-based medical education." (Cotton, 2009, pp. 143-4)*

The criteria produced are treated as 'nationally derived', representative of national expert opinion, due to the treatment of the subjects as research participants. Logics of consensus and research informing practice are then used to position these nationally derived criteria as suitable for implementation in medical education across the country.

Summary

In summary, new research participants are used within this field to justify the production of research. First, research is justified as producing unheard voices: research is claimed to produce knowledge previously unknown in practice, through the treatment of a particular social group as research participants. Research is justified in relation to production of, for example, patients, students and practice staff as research participants to make known issues about their participation in teaching. Secondly, research is justified as producing new

research participants, making *existing* voices visible within the research literature. A logic of consensus is used to claim the importance of reaching expert agreement to inform standardisation of national criteria. A second logic that research informs practice is used to claim the value of the consensus reached among experts as research participants, in order to justify the status of the knowledge produced to inform national criteria.

How is the researcher justified?

Introduction

How the research is justified determines the available subject positions for the researcher, and how particular ways of knowing are legitimated in relation to this position. This is useful for me to understand, both in relation to my own future participation in this field as author, but also more widely to understand how this field produces a unified or dis-unified perspective on research placements. This section examines how texts make available particular subject positions for the authors as a researcher, and how these are associated with particular qualities and legitimate particular ways of knowing. Many of the authors of research papers are GPs or GP academics, researching their own field of work. I was curious, therefore, to examine how ways of knowing are made legitimate for the authors both as researcher and practitioner.

In Chapters 3 and 4, I examined two contrasting ways in which placements are characterised. Teaching in the general practice setting is often justified within texts through a gaze of discovery, for example in relation to the integration of clinical service and teaching service. Placements are, however, often produced within the texts through a deciphering gaze, compartmentalising knowledge said to be available, taught and learnt in the general practice setting. This produces compartmentalised subject positions for the GP as teacher or clinician and patient as subject with psychosocial or physical disease. There are similarities in relation to the production of subject positions for the researcher. Introductory and discussion sections of papers, for example, often make available integrated positions for the researcher-practitioner. This contrasts, however, with the dominant position made available in the methods sections of papers and description of the ways in which the research process was conducted by the author.

Research is most commonly justified as evaluation and these texts produce a subject position for the researcher as evaluator of placements. The teaching of a compartment of knowledge is then, for example, evaluated as an innovation. A number of rules and techniques used to justify this position make the researcher position distinct from practice.

Research is justified in some texts as hearing voices. A second subject position is therefore made available for the researcher as making voices heard. This position is sometimes governed by similar rules as the evaluator, attempting to make distinct ways of knowing as practitioner and researcher. Occasional instances are, however, found within this field, which not only position the researcher as making voices heard, but also make legitimate ways of knowing both as researcher and practitioner. I will now examine each of these in turn attending to how practice and research are treated as valid ways of knowing; how the characterising qualities of research and practitioner are produced; and how authors move between these positions and exclude one from another.

Dual position as researcher-practitioner

Texts are often written by GPs who are clinicians and organisers of teaching. Different ways of knowing are often attributed, however, within the texts to the GP as researcher and GP as clinician-teacher. Experiential knowledge of an organiser might, for example, be used to contextualise a research study or make claims about the significance of the research findings, complementing the research. At other times, dissonance is produced between what is knowable in teaching practice and knowable through production of research. I will now illustrate each of these categories.

On some occasions, the dual role of authors are used to complement each other, for example, using practitioner knowledge to contextualise research findings. In this text, for example, the authors discuss the results of their cross-sectional survey of GP teachers, drawing on their experience as organisers of teaching to contextualise their rationale for conducting this research study. I have chosen a study to illustrate this, which examines if the presence of medical students affects quality in 'normal' general practice consultations:

> *"**To our knowledge**, no studies have looked at the effect that a student 'sitting in' on a 'normal' general practice consultation may have on the perceived quality of care experienced by the patient. **By 'normal', we mean** general practice surgeries in which the consultation time remains at normal length, generally between 5 and 10 minutes… **In reality, we know** from considerable experience of organising these placements that GPs sometimes block off the occasional consultation slot (usually 1 or 2 per surgery) in order to catch up with their timetables." (Price, 2008, pp. 374-375)*

The subject as researcher(s) is positioned as integrated with the role of the author as practitioner. The authors initially position their research as addressing a gap in existing research, justifying their study exploring how a student's presence might affect a patient's experience of the consultation. They then draw upon their role as practitioner and organiser of placements 'in reality', to provide some additional contextual information about the nature of 'normal' consultations which are to be investigated in this research. An integrated position is thereby produced within the text for the author as both subject as researcher and subject as practitioner.

On other occasions, the integrated role of author as 'subject as researcher' and 'subject as practitioner' is used to illustrate dissonance between what is known or expected experientially, and what is known or established through production of research:

> ***"I had also expected more referrals** in the teaching situation but instead there were fewer, particularly referrals within the primary care team."*
> *(Freeman, 1981, p. 113)*

A contrast is made between what was previously expected by the author as subject who practices, with the production of new knowledge by the subject as researcher. Here, a GP academic expresses surprise between what he had expected based on his experience as a practitioner and the results achieved through the research process, which audited and compared measures of clinical management when a student was present or not within a consultation.

In summary, there are instances within this field, usually within the introductory and discussion section of papers, where a position is produced for the author where both research and practice are valid ways of knowing. An author, for example, is positioned as researcher, but draws upon contextual knowledge from their position as practitioner to complement the description of the study. Similarly, an author might draw upon their knowledge as practitioner to illustrate dissonance between what is known in practice, and new knowledge produced by the subject as researcher. I will now go on to examine the subject positions made available for researchers in relation to *doing* research and description of methods.

Researcher as evaluator

Most of the research in this field is justified as an evaluation of general practice placements. This produces a subject position for the researcher as evaluator. While many texts are written by dual researcher-practitioners, the production of researcher as evaluator draws upon a variety of techniques and rules to make the subject positions of the researcher and practitioner distinct from one another, attributing different ways of knowing to each subject position. This creates a tension and power imbalance between the author as practitioner and researcher evaluating that practice. This separation is dealt with in a variety of ways through adherence to particular rules to justify the researcher position.

One technique used to justify the position of the author as an evaluator is the use of a research structure to frame writing about a teaching programme. Using this technique, the work of the author as practitioner is made valid through its treatment as a research text. The author provides a description of the teaching programme, legitimated through its being evaluated by the author as evaluator. The position of the author as evaluator is claimed through structuring the text as Introduction, Method, Results and Discussion (IMRAD) in order to justify the author as producing research, rather than providing a description of the teaching as a teacher. In, for example, Armstrong's paper, the sections entitled methods and results are, in fact, descriptions of teaching methods and outcomes, rather than reporting of the application of a research method and results produced. It is not until the final section of the paper, that the text reports a short survey evaluation of student feedback about the course, embedded within the discussion section. The researcher-evaluator position is, therefore, justified through the use of an IMRAD structure and dedication of a small section of this text to an evaluation of the described teaching.

Another technique, used to justify the position of the researcher as an evaluator and make this distinct from the position of the practitioner, is to draw on research terminology within the description of the teaching process. Research language is used to describe the learning process, supporting the positioning of the author as a researcher and evaluator of the teaching. This use of research terminology positions the work of the researcher in relation to the reported evaluation:

> *"Prior to session 3, each group of eight students collated the **information gathered** during their community visit, then discussed and agreed the main issues. The **students were therefore unknowingly performing triangulation**, the combination and comparison of information gained from different*

*perspectives ...The development of this **group analysis** was facilitated by specific questions on pre-printed overhead acetates." (Davison, 1999, p. 58)*

Some texts explicitly describe how the author has attempted to deal with their dual role as researcher-evaluator and practitioner. This is often done in ways to maximise claims that ways of knowing as a researcher are made distinct from ways of knowing as a practitioner. In this instance, the author claims the distinction between their roles as practitioner and researcher during the interview and analysis process in terms of 'objectivity':

*"As an '**in-house' evaluator**, it was relatively easy for me to gain access to the interview sample and **I had some insight** of the issues which might be relevant to the students and GP tutors. However, I was aware of the **risk** that **my inside knowledge** could **compromise my objectivity** and **influence what was revealed** in the interviews. To counter this possibility I **continually questioned my own influence** on the data collection and analysis. I looked specifically at negative cases and I have **minimised my own interpretation** in presenting the results." (Hampshire, 1998, p. 499)*

The dual role of the author as practitioner and researcher is made explicit. The author describes certain advantages for the research in terms of access and knowledge about which issues might be relevant to participants. This is countered, however, by adherence to rules for the subject as researcher. These rules concern her 'objectivity' in relation to her experiential knowledge, during data collection. These rules include her use of reflexivity and contrasting negative cases, making distinct her ways of knowing as researcher and practitioner: using these techniques to counter her use of experiential knowledge to interpret the results.

A further way used within these texts to distinguish between the subject positions of researcher and practitioner is to include a *non*-practitioner, experienced researcher in the research team:

*"An **independent, non-medical researcher** with wide experience in health services research interviewed teachers to **encourage frankness** in their assessment of teaching…" (Hartley, 1999, pp. 1169-1170)*

The inclusion of an 'independent' researcher with experience of research, but not of teaching practice, is used to legitimise the position of the subject as researcher in relation to the 'frankness' of participants during the interview process. This treats the independence of the subject as researcher as a way of better accessing truthful or honest responses from participants. Independence is a rule used to claim distance, not only from the research context, but also from other researchers during the analytical process. In this text, for example, the subject as researcher is legitimised through their adherence to independent analysis:

> *"Two **authors independently analysed** the data. There were no notable discrepancies in their conclusions.... We explicitly looked for **negative effects** of teaching on doctors and their practices and found very few despite using an **independent researcher** to facilitate disclosure of negative feelings.... There was a striking **homogeneity** of responses, despite **planned sampling for maximum variability**." (Hartley, 1999, pp. 1169-1170)*

The evaluator position is claimed here in relation to the separation of the researchers from one another; the inclusion of a non-practitioner researcher; and the use of techniques to focus on negative issues to counter any positive bias produced by the dual role of the practitioner-researcher. The success of these techniques in producing a legitimate evaluation of the placement is claimed in relation to the reaching of consensus in the analysis, despite conducting the research to produce maximum variation.

In summary, there is a variety of ways in which the researcher as evaluator is made distinct from the subject as practitioner. These rules include the use of IMRAD structure and research terminology to position the author as an evaluator of practice; the subject as researcher claiming to maximise their objectivity and reflexivity during the research process; and the researcher(s) claiming independence from experience through use of non-practitioner researchers in the team, and claiming independence from other researchers during the research process.

Researcher as making voices heard

Some research is justified in relation to the production of voices in the text: producing new research participants and subsequently new knowledge. This makes available a subject position for the researcher as making the voices of research participants heard. Many of these texts draw on similar rules used to claim the position of the evaluator, making research

distinct from practice. These use explicit pre-determined frameworks, such as interview schedules or questionnaires, to shape in advance the researcher-participant interaction. There are, however, exceptions within this field that treat the researcher-participant interaction as co-constructed. These draw upon rules which make explicit the researcher's theoretical perspective and reflexive stance during the research as ways of making legitimate integrated practitioner and researcher ways of knowing. I will examine each of these in turn.

Some texts produce the researcher subject as making voices heard, using claims about the pre-determined nature of the researcher-participant encounter. This text, for example, describes how the content of the interaction was determined in advance of the interview:

> *"The **interview topic guides** were **developed by consensus by the research team** using **data from preliminary questionnaire responses** and included participants' experiences of teaching, impact on patients' well-being, differences in learning psychiatry in general practice … and attitudes to mental illness."*
> *(Walters, 2007, p. 102)*

The researcher is treated as making the voices of the participants heard, including discussion of participant experiences of teaching. The nature of the interaction between researcher and participant has, however, been pre-determined in a number of ways using consensus between research team members, drawing upon responses from questionnaires, and categorising areas of relevance to discuss during the interview.

Other texts produce a different position for the researcher as making voices heard, treating the interaction as a co-construction between participant and researcher. Whereas in the category above, the authors describe techniques to pre-determine and control the content of the interaction, here, the authors describe techniques, which make space to hear participant experiences. This treats the participants' ways of knowing, in relation to their experiences, as a valid way of knowing. This treats the researcher not as doing research on the participant, but rather as doing research with the participant. This text, for example, compares student experiences of general practice and hospital-based teaching:

> *"We interviewed students in focus groups **before and after their placements**. In semi-structured interviews they were **asked about their experiences of learning through clinical contact**…In order that the **discussion remained***

***responsive to student understanding and experience a flexible interview schedule was devised**, based on a number of **open-ended questions**."*
(Thistlethwaite, 1999, pp. 678-679)

Both Walters et al. and Thistlethwaite and Jordan claim to use semi-structured interviews, positioning the researcher as making participant voices heard. However, the ways in which the participant voices are said to be produced contrast. The legitimacy of the researcher as producing valuable knowledge is claimed in different ways. While the first is an example of the researcher claiming to pre-determine the nature and content of the interaction, this second extract is an example of the researcher being positioned as responsive and adjusting to participant experiences and priorities arising during the interview. The researcher is said to use a 'flexible' interview schedule and 'open-ended' questions, in addition to the use of some pre-determined structure. Similar techniques are described in this next text, which explicitly highlights the value attributed to the interpersonal interaction between researcher and participant as both addressing pre-determined topics and co-producing data:

*"Reflecting on the **importance of the interpersonal relationship of the interview** (Kvale, 1996), participants were **encouraged to share perceptions of their involvement** in pre-arranged undergraduate teaching clinics within the practice… A topic guide facilitated key aspects for consideration. The **interviewer also followed up areas of interest identified by participants**."*
(Lucas and Pearson, 2012, p. 279)

There is a contrast then in this field between how the researcher claims to make participant voices heard. The first uses rules such as pre-determining the content of researcher-participant interaction, and research team consensus. The second uses rules, which legitimate space for participants to determine (to an extent) the content of the interaction, at the time of the interview. This second approach legitimates the experiential knowledge of the participant as a valuable feature of the production of research knowledge. The latter approach also legitimates experiential knowledge of the researcher using rules, which make the researcher's ways of knowing explicit to the reader. This is done in relation to the author's theoretical perspective and reflexivity. To illustrate this, I have chosen a text that reports a phenomenological analysis of patient experiences of teaching encounters:

*"The research was conducted in line with a **conceptual orientation towards communities of practice theory** and **used phenomenology** as a way of **exploring patients' lived experience** in depth. **Minimally structured interviews** were carried out… following … general practice appointments in which students were being taught." (McLachlan, 2012, p. 963)*

The researcher making participant voices heard is not positioned as separate from data production, nor is this position justified in relation to claims about repeatability, consensus or standardisation of process. Instead, the researcher is positioned as facilitating and legitimately co-constructing the data with the participants, to explore experiences about the participants' experiences of teaching. The researcher's orientation (here use communities of practice theory and phenomenology) during production of data and analysis is not made separate, but rather made explicit as a valuable element of the research.

The experiential knowledge of the researcher is dealt with in different ways within this field. In some instances (both in justifying research as evaluation and making voices heard), researcher reflexivity about their experiential knowledge is used to make claims that the researcher is separating their experiential knowledge from the research process. In contrast, in some texts, which claim to make voices heard, reflexivity is used to make explicit the researcher's experiential knowledge as a legitimate way of knowing within the research process:

*"**Before starting the study**, EM wrote a document setting out her **preconceptions** about patients' experiences of involvement in medical education **in order to help her understand her preconceptions** and **how they might affect her interviewing and data interpretation**. She **referred back to this document repeatedly during the research**…. **Communities of practice theory provided sensitizing concepts** for this exercise [template analysis method], but the actual themes arose from close inspection of the data…" (McLachlan, 2012, p. 966)*

Reflexivity is used to make different claims within this field. The evaluator and some researchers making voices heard use reflexive insights to claim avoidance of their impact on the research process. In contrast, here the researcher does not claim to make their own perspective and experiential knowledge separate, but rather makes this explicit within the

research so that it can be considered as part of the research context and way in which the research was produced.

In summary, the justification of research as hearing voices produces a subject position for the researcher as making voices heard. Some positions within this category are claimed in relation to rules similar to those of the evaluator. These make distinct ways of knowing as researcher and practitioner. They also claim legitimacy in relation to rules that attempt to control and pre-determine the nature of the researcher-participant interaction. Other texts within this category treat the participants' way of knowing as a legitimate element of the research using techniques to treat the interview process as co-constructed. This legitimates experiential ways of knowing for the participant and for the researcher. While reflexivity is used in the evaluator category as a way of making distinct practice and research knowledge, here reflexivity and theory are used to make explicit a researcher's experiences as practitioner a legitimate way of knowing within the research process.

Conclusion

In conclusion, research is justified in a number of ways (see Table 3). One dominant justification for the production of research is evaluation. This positions general practice placements as innovative and thereby worthy of evaluation. GMC policy is often used to support existence of general practice placement innovations, but simultaneously reinforces its treatment as un-established in relation to hospital-based placements. Sometimes, the general practice placement is re-invented as innovation, through the evaluation of new teaching methods in the general practice setting. Some research is justified as hearing voices. This time, a claim is made that the research is producing new research participants, and thereby new knowledge about placements. Sometimes research is justified as hearing voices previously unheard. At other times, research is justified as hearing voices that are heard in practice, but previously unheard in research.

Object: legitimate research characterised as…	Subject positions produced	Concepts or Logics
Evaluation	Researcher as evaluator of practice. Made distinct from practitioner-clinician roles using: a) IMRAD b) Research terminology c) Objectivity d) Independent researchers	Research informs practice
Innovation: a) placements as innovation b) research participants as innovative / new c) teaching methods as innovative / new		Placements as new and un-established / unknown GMC policy justifying existence of placements, but undermining their legitimacy as un-established / re-invented / new
	Dual researcher-practitioner (sometimes visible as discussant: contextualising research rationale or commenting on research results in relation to practice).	
Hearing Voices: a) Bringing in unheard voices (making new knowledge through production of research participants) b) Hearing existing voices (producing experts as research participants)	Researcher as making voices heard: a) using pre-defined / consensus framework (practitioner as subject who intrudes on research process) b) conceptualising interaction as co-constructed + using theoretical lens / reflexivity to make researcher-practitioner legitimate	Legitimising experiential knowledge

Table 3: Summary of Analytical Categories for a 'Justification of Research'

A number of logics are drawn upon within the justifications of research. First is a logic of innovation, providing a justification for the evaluation of placements as new. This is often linked with GMC policy that is used to support the existence of placements, but paradoxically position the placements and GPs as un-established in relation to hospital-based teaching and faculty. A logic that research informs practice also underpins a number of ways in which research is justified in this field. Research findings are, for example, positioned as a way of informing practice and policy recommendations. This logic is also evident in the rules used to position a 'subject who researches' as an evaluator, or pre-determining the production of knowledge when positioned as 'making voices heard'. This produces a tension for authors

as researchers and practitioners within these texts, providing them with authority in their role as researcher while often undermining their role as practitioner, and treating this dual role as a limitation, rather than a strength, of the research. There are occasions within this field when the researcher is positioned as making voices heard and legitimating the role of experience in shaping research: both through making visible participant experiences of workplace-based learning, and treating the interaction between researcher and participant as an explicit co-constructed process.

Chapter 6: Strategies and Discussion

Introduction

This thesis maps the discursive field of research texts about UK undergraduate general practice placements. I draw from a broad archive of published research texts about general practice placements for medical students. I use instances from this archive to show how discursive practices within this field are evidenced in texts. The use of a Foucauldian approach to discourse analysis has made visible within the texts the power relations between different elements of the discourse. In using a Foucauldian approach to discourse analysis, there is a methodological tension between the recognition of *dispersion* within a discursive field, and the production of an analysis which posits a *coherent* whole or underlying episteme (Howarth, 2000, p. 63). I have identified a number of elements to this discursive field. In this chapter, I examine the relations, alignments and paradoxes between these elements.

In my analysis, I have produced two analytical categories contrasting ways in which general practice placements are characterised through a gaze of discovery or deciphering. This makes visible a number of dyadic tensions between general practice and hospital teaching; use of pre-determined and workplace-based curricula; and tensions between factual and experiential knowledge. I have examined how research is justified and identified tensions between ways of knowing as researcher and practitioner through, for example, the positioning of research as generating new knowledge about practice, and the positioning of the researcher as an evaluator. In this chapter, I consider how the characterisation of general practice placements through a gaze of discovery and deciphering relate, and how these relate to the ways in which production of research is justified. I consider how the results of this analysis connect to existing literature and how this topography might inform future directions for research in this field.

Mapping the discursive field of research about general practice placements

In this section, I will summarise the objects, concepts and subject positions identified in each results chapter. I will then go on to examine how these relate to one another and the overall strategies this produces within the field.

Gaze of Discovery

Many texts within this field discuss the educational and political importance of general practice placements, by characterising general practice placements through a gaze of discovery. For example, emphasising the importance of students learning about Generalism, and promoting the work of GPs in relation to career choices. Many texts go on, however, to characterise placements within the research, using a gaze of deciphering. Where a gaze of discovery is used, a range of objects, subject positions and concepts are evident. General Practice placements are characterised as patient-based interaction; and experiential knowledge, producing subject positions for patients including 'subject with contextualised disease; 'subject as educator'; and for the GP as 'teacher-clinician' and 'facilitator of learning'. The student is offered subject positions as 'participatory learner', and sometimes as 'intruder' or 'disruption' to 'normal' clinical practice, particularly when treated as an observer rather than participant in the teaching encounter. Instances of concepts or logics used to characterise placements within this gaze, include treating general practice placements as preparation for professional practice, and legitimation of workplace-based learning for undergraduates in the general practice placement.

Gaze of Deciphering

Many research texts in this field characterise general practice placements through a gaze of deciphering. Through this gaze, general practice placements are characterised as a number of specific elements or categories of knowledge including chronic disease; basic specialised disease; and elements of interactional knowledge such as psycho-social knowledge; attitudes; and communication. This produces a number of subject positions within the texts for the patient (often pre-selected) as 'subject with disease'; distinct from 'subject as psycho-social entity'; and division of the GP position as 'teacher' *or* 'clinician'. Concepts include the compartmentalisation of learning and concern the division or categorisation of knowledge in various ways, including a Cartesian mind-body split and division of learning as knowledge, skills and attitudes.

Justification of research

Research is justified as evaluation and hearing voices. The dominant way in which research is justified is as evaluation of general practice placements and teaching methods in the general practice setting. This draws upon a logic of innovation, supported by a logic of GMC policy, to provide a rationale for evaluation. Research is also justified as hearing voices. Sometimes, research is justified as hearing unheard voices, others as hearing voices heard in practice, but not previously in research. A logic of consensus and standardisation is used

to support production of research. Research is also often justified in relation to a logic that research informs practice. Subject positions are made available for the researcher as evaluator and making voices heard. These draw upon particular rules to justify the subject position of researcher. Texts produce an evaluator position, drawing upon rules, which separate the researcher subject from the researcher-participant interaction and ways of knowing as practitioner.

Justification of research as hearing voices produces a subject position for the researcher as making voices heard. Some texts position researcher ways of knowing as dominant over the participant, using pre-defined techniques to control the researcher-participant interaction. Others use techniques to legitimate the research interaction as a co-construction of knowledge. This valuing of participant experiential knowledge is also evident in the legitimating of researcher experiential knowledge, making explicit the researcher's reflexivity and theoretical perspective in reports of data production and analysis, rather than claiming to separate or remove this way of knowing from the research.

Strategies

A number of strategies are identified in this overall discursive field. While some produce a unified strategy, others produce misfits or dissonance between the ways in which general practice is characterised and research justified. This makes visible how ways in which research is justified relate to the ways in which general practice placements are made thinkable in this field and opens opportunities to consider 'unthinkable' alternatives for future research.

General practice placements as supplementary

There is a unified strategy across both the characterisation of placements and justification of research, which positions general practice placements as supplementary to hospital-based teaching. The dominant way in which general practice placements are characterised in this field is through a gaze of deciphering. General practice placements are produced as supplementary to hospital-based teaching when characterised through a gaze of deciphering. Through this gaze, placements are positioned as providing specific compartments of knowledge to address pre-defined curricula categories. These compartments range from characterisation as interactional knowledge, to basic specialised knowledge. Crucially, however, they are treated as providing what is *not* available elsewhere in hospital-based curricula, filling in curricula gaps.

The dominant way in which research is justified in this field is as an evaluation. This frequently draws comparison between general practice and hospital-based teaching. Texts draw upon a logic of innovation, in order to claim the relevance or purpose of the evaluation, treating general practice placements as invented or re-invented teaching. Texts frequently draw upon GMC policy to support the existence of general practice placements as fulfilment of policy requirements. These, however, position hospital teaching as traditional and established, in contrast to general practice as new and thereby un-established. This produces a hierarchical power relation between hospital and general practice spaces and faculty, again positioning general practice placements as supplementary.

General practice placements as different

A second related strategy positions general practice as different. General practice placements are characterised within this discursive field, through two different gazes. Both of these fulfil a strategy of treating general practice placements as different. The nature of the difference, however, produces very different possibilities for what is 'thinkable' and 'unthinkable' and subsequent power relations. In this section, I examine how these strategies of difference shape ways of thinking in texts about what is and is not taught and learnt in general practice placements.

Through a gaze of deciphering, general practice placements are positioned as teaching *only* what is different or not available within the hospital setting. This produces power imbalances in the value attributed to types of knowledge allocated to general practice. Communication knowledge is, for example, treated as something not taught in the hospital and of different value or importance to disease-based or physical knowledge taught in the hospital setting. A deciphering gaze also treats particular types of knowledge as invisible or 'unavailable' in the general practice setting, thereby reducing the status or perceived importance of the GP tutor and general practice placements.

Through a gaze of discovery, general practice is characterised as different also. However, the difference is produced in relation to contrasting disciplines, rather than particular compartments of knowledge. General practice is characterised as teaching what GPs do in clinical practice, or the discipline of Generalism. This characterisation contrasts with a gaze of deciphering, in making visible commonalities in the availability of knowledge across general practice and hospital settings. There is, of course, still potential for dyadic power relations between Generalism and other hospital-based disciplines, but the visibility of

commonalities produces the two settings as more equivalent and thereby more equal in status and value.

These two gazes use two contrasting pedagogic models to shape what is characterised to be taught and learnt in the general practice placements. Some research texts characterise placements as workplace-based learning, focussing upon experience of general practice clinics and interaction with patients. Other texts characterise placements as compartmentalised and pre-determined learning structured by a university (and often hospital-based) curriculum. These produce very different possibilities for what is thinkable and unthinkable for placements and related approaches to learning and its organisation. Characterising placements through a deciphering gaze, for example, produces the unpredictable and variable nature of general practice as problematic, focusing instead on controlling the content of teaching and student-patient interaction, through selection of specific patients for teaching clinics. A discovery gaze, in contrast, characterises placements as integrated with service. This is, however, sometimes treated as problematic within research texts, which position the student as an intruder or disruption to provision of service. Making general practice placements strategically thinkable within texts as 'not different' could, for example, produce placements in texts which are characterised as long or extended placements, producing a position for the student as normalised, rather than intruding, within the practice setting.

No research to date has specifically looked at the tensions between workplace-based and pre-determined curriculum learning, in research texts. Some authors have, however, reported exploration of these tensions in practice. Atkinson, for example, conducted field-work on hospital wards in the 1980s, and drew an analytical distinction between patients in medical education as 'hot' or 'cold' (Atkinson, 1975). By 'cold', he was describing student-patient encounters e.g. on a ward, where the patient has already been 'clerked' by a professional and selected for teaching (e.g. due to particular disease associated signs) (Atkinson, 1975). Fox discusses how the process of diagnostics for the student is therefore retrospective and likely to give a raised sense of certainty as they try to guess what the 'right' answer or outcome to this encounter might be (Fox, 1980). In contrast, if a patient is 'hot', the student's journey is contemporaneous with that of the professional. In this situation, the student is discovering the patient's needs with (or even before) the professional, but more likely uncertainties inherent in diagnostic processes and the presence of illness without disease and vice versa (Beresford, 1991).

Apple, in his book ‘Educating the right way’, highlights the underpinning politics of knowledge involved in the allocation of particular knowledge to particular settings, who chooses this and how it is justified (Apple, 2006). He argues, for example, that a neoconservative discourse is used in school education to treat and allocate certain, generally ‘fact based’ knowledge, as ‘real’. Examining what is made thinkable in the discursive field of research texts about general practice placements allows us to examine how particular knowledge is allocated to the general practice (and hospital) settings, and the power relations this produces. Treating general practice placements strategically as ‘different’ shapes what is thinkable in terms of the assessment of medical education knowledge and the contribution of general practice placements to future professional practice. To use the language of research (Greenhalgh, 1997, p. 109), characterising general practice placements through a deciphering gaze, establishes the value or legitimacy of placements, making them thinkable as ‘reliable’; making explicit connections between placements and their accountability in fulfilling a curricula content blueprint map. In contrast, characterising placements through a discovery gaze establishes the value or legitimacy of placements, making them thinkable as ‘valid’ or authentic to the future careers of practising doctors (if a career in general practice, rather than hospital medicine, is made thinkable).

This analysis does not include curricula or pedagogic texts, but highlights an important point of connection between the discursive practices of research and curricula. If, then, this discursive field shifted treatment of what is thinkable about general practice placements in research texts, characterising them as equivalent rather than different, might this create possibilities to think differently about the character and boundaries between placements in medical education?

Experiential ways of knowing

This section discusses how as a dominant strategy, this discursive field does not legitimate or de-values experiential knowledge. This is evident both in the way in which placements are characterised and research justified. There are ways within this discursive field in which experiential knowledge is made legitimate, but these are not positioned as dominant, producing hierarchical dyads in relation to experiential ways of knowing.

First, I will discuss the characterisation of placements. Through a dominant gaze of deciphering, experiential or interactional knowledge are made separate to disease-based knowledge, locating these as separate elements of the curriculum and producing hierarchical relations between these topics and spaces in which teaching takes place.

Through the less dominant gaze of discovery, experiential knowledge is made visible. A key feature of the characterisation of placements through a gaze of discovery is the production of a subject with contextualised disease for the patient, legitimating their participation in the encounter as an 'educator'. Experiential knowledge is also legitimised in the production of a subject as 'participatory learner' for the student, and the GP as 'facilitator of learning', making possible student-patient interaction. The student is said to be learning through experience, and the patient's experience made visible as a valuable element of knowledge to be taught. The clinical experience of the GP-teacher is also legitimated through the characterisation of the placements as workplace-based service, rather than a separate curriculum component.

Experiential knowledge is also de-valued in the dominant way in which research is justified. The fields of research and teaching overlap within these texts and highlight challenges for university teachers attempting to respond to institutional pressures to produce research publications, while also attempting to justify the credibility of their teaching experiences and innovations in a legitimate publication space. The dominant way in which research is justified within this field is as evaluation. Ways of knowing as a researcher are positioned as dominant in relation to ways of knowing as a practitioner: the researcher evaluating practice. Similarly, practitioners' descriptions of teaching programmes are only made legitimate, through treatment of the author as a researcher using evaluation methods; and research structure and terminology in texts. Further, reflexivity is used to claim separation between practitioner experiential knowledge, and the research process.

There are contrasting, less dominant, ways in which research is justified and the researcher produced which legitimate experiential ways of knowing. The dual role of the author as teacher and researcher is, for example, sometimes made explicit in sections claiming the significance of research findings. A position for the dual researcher-practitioner is occasionally produced within the reporting of how research was done. Some texts, for example, position the researcher as 'making voices heard', using techniques to legitimate the research interaction as a co-construction between researcher and participant. Similarly, the research position is claimed in relation to making their experience as a practitioner and theoretical perspective explicit through reflexivity.

Experiential ways of knowing are made legitimate within the related field of medical education research, with growing attempts to make visible workplace-based learning in context (Evans, 2012). Studies have, for example, examined how workplace-based

education is shaped by the interplay of historical, cultural, material, structural and normative factors (Eraut, 2007b Gherardi, 2006) and dynamics of power and control in practice (Engeström, 2007). It is possible, then, that these will provide productive ways for thinking about future research of general practice placements, making thinkable and perhaps more dominant, methods which examine learning *in practice* facilitating characterisation of placements through a discovery gaze and producing greater legitimacy for the author as researcher-practitioner, in future research texts.

Evidence-based medical education

There is an intimate relationship in this field between research and teaching. This analysis has produced a number of ways in which research ways of knowing are positioned as distinct and dominant within the texts, in relation to experiential or practitioner ways of knowing. These include the production of a researcher as evaluator of practice, and making description of teaching valid within the text through its treatment as research and evaluation. There are instances where experiential participant and practitioner knowledge are treated as legitimate but, as discussed in the previous section, these are not dominant within this discursive field. There are other forums through which teachers can communicate with other professionals, but in terms of individual and organisational recognition of work, research texts remain high stakes. It is important, therefore, to consider how dominant ways of justifying research about placements might be developed.

The relationship between research or 'evidence' and professional practice has been much debated. These debates attend to the tension between the operation of 'rules' and the nuanced application of those rules in a particular context (Hargreaves, 2007, p. 47) and the related suitability of different methodological and paradigm orientations of research (Gough, 2012). One powerful movement within medicine has been the 'evidence based medicine' (EBM) discourse. Parallels have been drawn between the production and application of research in medical practice, with teaching and education, attending to its relevance (Hargreaves, 2007) and challenges (Hammersley, 2007). Hammersley, for example, argues that while educational research is useful to inform public debates about educational issues, it should not inform the operational and contextually variant particularities of practice. Calls are, however, often made highlighting the need for more research to make clear which educational practices 'work', in what circumstances, and why (Hargreaves, 2007, p. 47). The field of general practice placements is no exception, and this analysis has identified 'innovation' as one particularly dominant way in which a need for further research about placements is argued.

One way in which the power dynamic between research and teaching is determined is the treatment of research as innovation within a discourse that values production of new knowledge. Justification of research in this field often draws upon a logic of innovation. Production of new knowledge is claimed in relation to the treatment of general practice placements, teaching methods, or research participants as new. Innovation has been identified by Martiaminakis as an important feature of discursive fields of knowledge-making in Engineering and Medicine (Martimianakis, 2011). She identifies innovation as a way in which knowledge is positioned as useful and marketable; a neoliberal commodity (Martimianakis, 2011). How teaching and research are positioned in relation to production of new knowledge is, therefore, important in shaping how these disciplines are treated within a discursive field of research texts.

Research is defined by the OED as 'the systematic investigation into and study of material and sources in order to establish facts and reach new conclusions' (OED, 2010). Teaching is defined as 'a body of knowledge acquired while being educated', or 'the process of receiving or giving systematic instruction' (OED, 2010). Within these definitions, research is treated as producing new knowledge, whereas teaching is treated as exchange of existing knowledge. Within a neoliberal framework, research becomes positioned as the more valuable and legitimate of the two, through its engagement with innovation and production of new knowledge. This thesis has, however, demonstrated how justification of research as innovation is problematic in a number of ways for general practice placements.

There are alternative available ways of justifying research as producing new knowledge, which do not produce placements as innovation. Treating research as 'making visible', produces available justifications of research as, for example, producing new understandings about existing processes and the inter-relations between learning contexts and organisational processes and arrangements. There are also alternative ways of treating teaching practice, which *do* characterise this process as production of new knowledge. The gaze of deciphering identified in this analysis consists of a pedagogic system, which treats learning in placements as pre-defined. The gaze of discovery, in contrast, draws upon a workplace-based learning logic of learning and treats learning as co-constructed between patients, students and teachers in practice. Viewed through this latter lens, teaching can be treated as a co-constructed process, producing new knowledge: blurring the boundaries with research and power hierarchies between the two. This has important implications for the ways in which it is thinkable to characterise placements and be positioned as a legitimate researcher.

Evaluation

The dominant way in which research is justified in this discursive field is as evaluation, producing the evaluator as legitimate through their use of techniques, which position them as external to the research context. Placements, teaching methods and research participants are treated as innovative. A logic that research informs practice is then used to justify the evaluation of innovation. The logic of GMC policy is also used to provide justification for the need and purpose of evaluation research: policy stimulating new teaching innovations, which need evaluating, and the evaluations informing further policy.

Definitions of evaluation and research are contested. Distinctions have been made between the two processes, distinguishing the use of methods and the object of study between the two: evaluation being interpreted for an immediate and local audience; and research interpreted in relation to theory and contribution to knowledge (Oliver, 2007). Oliver distinguishes research from evaluation in its use of theory, and production of new knowledge (Oliver, 2000). In this thesis, analysis showed how claims to production of 'new knowledge' were made in relation to evaluation of placements, participants or teaching methods as innovation. Others justified as 'hearing voices', made claims to produce new knowledge about placements in relation to generation of theory.

The history of evaluation has evolved in relation to quality assurance and accountability of teaching and learning practice, shifting between dual and at times divided aims to measure and / or support improvement (Guba, 1989). Related, methodological tensions have arisen between the use and value attributed to qualitative and quantitative methods used for evaluation (Hammersley, 1997). Quantitative approaches to evidence-based practice in educational research were, for example, enshrined in law in the US (Feuer, 2002). More recently, additional more illuminative methodologies, such as ethnography, have been used to explore unanticipated developments and the influence of context (Oliver, 2007).

The use of different evaluative methodologies produces a range of challenges for the researcher as evaluator. An evaluator can be positioned as 'external' or 'internal' to the research context (Oliver, 2000). In this analysis, legitimacy of the researcher as evaluator is claimed in relation to the researcher being positioned as external to the research context. Some justifications of researchers as making voices heard, by contrast, are claimed in relation to the position of the researcher as 'internal'. Claiming the legitimacy of the researcher as 'internal' produces opportunities for the researcher to legitimately claim their

contextualised position as a teacher-practitioner, engaging a different set of approaches to research and / or evaluation.

Whatever the method used, the process of evaluation is intimately connected with issues of power, politics and value judgments (Esterby-Smith, 1994). Evaluation can be contrast with research as having an explicit utilitarian purpose: a means to an end (Oliver, 2007). If evaluation seeks to inform subsequent action (Patton, 1997), to improve, change or determine allocation of resources (Oliver, 2007), then important ethical questions emerge about whose actions are supported and the power relations this produces. Some have argued for a shift in the legitimacy and perceived value of evaluation (Oliver, 2000). There are still, however, tensions within the academy between the value attributed to knowledge as teaching-related scholarship and knowledge treated as 'research' (Cunningham, 2014). So what power relations are produced through the justification of research as evaluation in the discursive field of general practice medical education research?

Evaluation is treated in this discursive field as the dominant thinkable way in which research can be justified. This produces a number of opportunities in relation to the connection between research and practice, and purpose responding to and informing policy. Evaluation texts could, for example, be used to support allocation of resources to general practice education; justify strategic initiatives in the general practice setting; or empower change and future support of general practice placements. Justifying texts as evaluation also provides a justification for the researcher-practitioner as legitimate through their 'external' position as evaluator. It is therefore thinkable for an author to conduct research - fulfilling a number of scholarly requirements - while evaluating their own teaching programmes, thereby providing some connection between their teaching and research activity.

The dominance in this discursive field of justifying research as evaluation, however, also produces a number of challenges. Particular approaches to evaluation are used in this discursive field, which conceptually align with the characterisation of placements as compartmentalised interventions, or pre-determined elements of knowledge. Knowledge about placements is, therefore, produced through a particular lens, which examines their value in relation to pre-determined curricula, rather than in relation to principles of workplace-based learning. A second challenge is the production of power relations between this and other discursive fields of research. While evaluation is used in these texts in order to claim legitimacy of research, some argue that evaluation is *not* regarded as a legitimate way of researching, thereby marginalising the efforts of teachers to engage in practice-based

research (Oliver, 2000). Despite, then, the author's efforts in this field to justify their research as legitimate through its position as evaluation, this may in fact be challenging the legitimacy of the text as 'research' and its related value, within a broader research field. Processes such as the Research Excellence Framework (REF), which determine the monetary value of research in the academy, might then not recognise the value of this research field due to its claims to legitimacy as evaluation.

In summary, the dominant way in which research in this field is claimed to be legitimate - attempting to promote general practice placements and research about this topic as evaluation – provides some opportunities, but is also problematic. Justifying research as evaluation challenges the possibilities for characterisation of placements and the legitimacy of texts in the broader field of research. Exploring less dominant approaches in this field, such as justification of research as 'hearing voices', might offer productive and alternative ways, enabling texts to be recognised as 'research' through use or production of theory as new knowledge. Positioning the researcher as making voices heard, might also address some of the challenges facing dual researcher-practitioners in this field, rather than attempting to claim legitimacy of researchers as evaluators external to the research context.

Conclusion

In conclusion, this analysis has produced two ways in which general practice placements are characterised within this field, through a gaze of discovery or deciphering. A number of strategies are produced within this discursive field (see Table 4). Characterisations of placements through a gaze of discovery make visible the workplace-based nature of placement knowledge and conceptualise clinical service and teaching, and the subject positions of GP and GP teacher, as combined. This positions both student and patient as active participants in the teaching encounter and makes visible the embodied nature of disease. This positions general practice placements as different to hospital-based teaching, but makes visible some of the commonalities. In contrast, a deciphering gaze compartmentalises knowledge, positioning placements as teaching what is *not* taught in the hospital. General practice placements are thereby treated as different to hospital as early or basic aspects of a pre-determined curriculum. This produces the pre-selected patient and GP as split, in response to the curricula divisions (including Cartesian mind-body and knowledge-skills-attitudes). General practice placements are thereby treated as supplementary to hospital teaching.

The dominant ways in which research is justified in this field use evaluation, positioning the researcher as an evaluator, and a logic of innovation. A logic of innovation, often supported by a logic of GMC policy, positions placements as new, justifying their evaluation, but also treating them as un-established in relation to hospital teaching. A logic of research as evaluation informing practice is also used to justify research. Research is positioned as dominant over practice through the position of the researcher as evaluator of practice, and the legitimation of teaching through its presence in research texts. The subject position of the researcher as evaluator, and sometimes as making voices heard, draws upon rules that pre-determine the research encounter. Some texts justified as making voices heard, position the researcher as producing voices using similar rules as the evaluator position to make practitioner and researcher ways of knowing distinct. Others position experiential knowledge as legitimate in their use of techniques to claim co-construction of data between participant and researcher; and explicit inclusion of the researcher's reflexive and theoretical perspectives in reports of data production and analysis. Dominant justifications of research align closely with characterisation of placements through a gaze of deciphering, and these latter justifications with placements through a gaze of discovery.

This discursive field of research about general practice placements is not isolated and connects with other discursive practices. The pre-determined, compartmentalisation of knowledge relates to alignment with broader pedagogic systems and neo-conservative allocation of knowledge to particular settings (Apple, 2006). This perspective aligns well with the production of researcher positions, which claim to pre-define the research process. Both produce dyadic hierarchical relations respectively between general practice and hospital placements; and research and practice ways of knowing. A dominant logic of innovation relates to wider neoliberal treatment of education and research, identified elsewhere in medicine and engineering disciplines of knowledge production (Martimianakis, 2011). A logic of innovation values production of new knowledge. This produces dyadic hierarchical relations between research and teaching ways of knowing, if only the former is treated as producing new knowledge; and a paradoxical treatment of innovative general practice placements as supplementary to hospital established or traditional teaching.

Strategy	**How strategy makes general practice placements thinkable**	**How strategy makes general practice placements unthinkable**
Supplementary	General practice placements 'filling the gaps' (e.g. communication, psychosocial knowledge, chronic disease) in curricula	Both general practice and hospital placements as core and equal value
	General practice placements positioned within research texts as 'innovation' and thereby un-established.	General practice placements as established and the 'gold standard'
Different	General practice placements as workplace-based learning; application of knowledge; and distinct from exam-orientated hospital placements.	Generalism as a speciality; assessable; and with commonalities between hospital and general practice placements.
	General practice placements as basic / early knowledge.	General practice placements as complex knowledge
	General practice placements as pre-determined curricula compartments, making visible to students only discreet aspects of the GP's clinical work (e.g. particular speciality disease management, without its integration with other patient concerns e.g. multi-morbidity, social context).	Generalist clinical work of the GP visible during teaching.
Experiential ways of knowing	General practice placements teaching experiential and / or interactional ways of knowing (e.g. communication skills), distinct from disease-based	Experiential ways of knowing as integrated with disease-based knowledge and learning: available across both hospital and general

	hospital knowledge.	practice settings.
	Researcher (as 'Evaluator' & some making voices heard) ways of knowing valued over ways of knowing as practitioner and participant.	Researcher as facilitator of knowledge production e.g. co-constructed with participants.
Evidence based medicine	Research informs practice	Research making practice visible in particular ways
	Teaching legitimated through description or treatment as research.	Teaching and research knowledge equally valued within academic institutions
	Research producing 'new knowledge' and teaching as exchange of existing knowledge	Research as making visible and teaching as co-constructed new knowledge.
Evaluation	Close connection with practice: legitimating the practitioner through engagement in research as evaluator of practice.	Researcher-practitioner or insider-researcher legitimated as producing valuable research knowledge.
	In relation to other fields of research: evaluation as intellectually limited, restricting what can be imagined and done. Justifying research as evaluation, thereby de-legitimating this field of research in relation to others.	Within medical and educational research fields, legitimating a broad range of ways to justify and conduct research, including evaluation and approaches by practitioner-researchers.

Table 4: Summary of Analytical Categories for Strategies

This analysis makes visible dominant thinkable ways in which research is justified and, related, general practice placements characterised. Many authors of research in this field are practitioner GPs and academics. Readers of this analysis might also, therefore, make associations or connections between ways in which this analysis has mapped this discursive field and how other related fields might be produced. Through making visible the thinkable, this analysis has also highlighted what are not dominant ways of characterising placements

and justifying research, or the unthinkable. If research does inform practice, this might help address some of the existing challenges faced by departments and GPs recruiting and sustaining teaching by clinicians in this setting.

Chapter 7: – Reflections and Conclusion

Introduction

> *"Writing has been a preoccupation for Foucault. In the writing of genealogy, questions arise about how under what conditions and in what forms the author appears in the 'order of discourse'; how she reveals herself in the discursive context of her narrative; which institutional constraints she accepts and what rules she has to obey." (Tamboukou, 2008, p. 108)*

In this chapter I reflect upon how I came to produce this thesis, how I have engaged with this process, and how I imagine this thesis will shape my, and perhaps others', future.

Becoming a researcher

There were several factors that triggered my initial interest in education and decision to study initially for a postgraduate Masters in Clinical Education and later for my EdD. As a child I was surrounded by family members who were teachers and spent many childhood holidays attending National Association of Head Teacher conferences while my father was on the national council. This interest in education developed further during my 'gap year', when I worked at the Royal Opera House Education Department. This work negotiated the boundaries between the elite and luxurious world of the Opera House itself, and the 'outreach' work to which the department was heavily committed, involving both bringing a range of audiences to performances, as well as taking production staff and performers to inner city and deprived areas and communities of London.

I began my undergraduate medical career in Bristol. There, I was part of the first cohort of the 'new curriculum' introduced following the publication of 'Tomorrow's Doctors' (GMC, 1993a). This document, in particular, supported the use of 'early patient experience' and the 'community setting' within undergraduate training. This was, in part, intended to address an expectation that over half those graduating from the course would become GPs. While providing a highly stimulating and clinically relevant learning experience, I was often struck by the cynicism presented to us by faculty (especially hospital consultants), expressing lack of trust in the amount and type of knowledge within our curriculum compared with the 'old course', as well as stigma about pursuing a career in general practice. This led me for many years to feel quite insecure about my own knowledge base and clinical expertise, finally

reaching some position of confidence when I attained distinction in my professional medical exams as a general practitioner (MRCGP).

Following completion of my clinical training and the Masters in Clinical Education, I began my professional career as both a GP and Clinical Academic in a university department of primary care. I encountered a variety of ways in which general practice placements were treated. While many appeared enthusiastic about the opportunities and quality of teaching in this setting, there were at times difficult negotiations with faculty to justify the space and value of placements. I also encountered quite contrasting expectations about what an academic should do, and be expected to achieve. While some focused quite clearly upon teaching and organisational activities, others (including the institutional machinery determining individual criteria for promotion) included many measures of scholarship as research. I therefore chose to embark upon an EdD, initially for quite strategic reasons around recognition and career progression. I soon became, however, fascinated with sociological research methodologies (Park, 2012c) and new ways of 'seeing' my professional world (Park, 2012b; Park, 2014a). Having previously focussed my attention only on the practical and technical aspects of professional knowledge *(techne)*, I became intrigued to understand how professionals know why and when to act *(praxis),* and the underpinning theoretical knowledge and perspectives shaping practice *(episteme)* (Aristotle, 1953).

In the early stages of the EdD, I undertook a module in Contemporary Education Policy. This included sessions with Prof. Stephen Ball who introduced me to the works of Foucault. I produced an analysis (Park, 2012a) using 'the policy cycle' (Bowe, 1992), which draws on the work of Foucault, to analyse the GMC document 'Tomorrow's Doctors' (GMC, 1993a). For my Institutional Focussed Study (IFS), I conducted a narrative study exploring a tension I had observed in my professional roles between negotiations of uncertainty in clinical practice and the performance of certainty to students during medical school teaching and assessment (Park, 2013). Towards the end of my IFS studies, I re-encountered Foucault's work, in particular the 'Birth of the Clinic' (Foucault, 1973), as an interesting way in which to make sense of the tensions I encountered in my professional worlds between knowledge forms and their associated value and power.

Having published some of my initial EdD work and engaged in various worlds of medical education research, I began to 'be' a researcher. I was invited to become chair of the Society of Academic Primary Care educational research group. As a novice researcher,

beginning to explore the world of research about general practice placements, it seemed a fitting beginning to use the EdD thesis as a way of becoming familiar with the existing research, but also gaining an understanding of the power relations, politics of knowledge and available positions for me as a researcher within this field. In this sense, I feel the thesis has been a 'success'. Under the guidance of my supervisors, I feel my ability to 'analyse' texts using a consistent research perspective and methodology, has been hugely improved. I now have a much better sense of what the field of research about general practice placements comprises, how I might like to position myself within that, and what sorts of ways of characterising general practice placements, that might produce.

Although perhaps better aware of the inconsistencies, I cannot claim to have achieved a coherent self or *telos*. While supporting my becoming recognised by my professional community as a 'researcher', I also feel that through engagement with this analysis, I have become an 'outsider'. Within different aspects of my research and writing to date, I have positioned myself within different discursive practices in order to produce a particular sort of knowledge. The writing space for this thesis feels to me to be within 'the margins of hegemonic discourses' (Lauretis, 1987, p. 18), facilitating the emergence of a new field of medical education research – a new research 'gaze' (Foucault, 1973). For me this has been highly productive – acknowledging that neither discursive practices within the texts nor my own textual production is devoid of conceptual tensions; and illuminating how differing discursive practices make available different subject positions – different possibilities for being. This thesis does not produce an answer or unified, core notion of 'truth' about general practice placement knowledge, nor my role within it. It does, however, I hope illuminate a matrix of possibilities, as temporary 'points of departure for going elsewhere, becoming other' (Tamboukou, 2008, p. 108). This map of the imaginable or thinkable within these texts can, I hope, be used as a basis for conversation within the medical education community to consider how pursuing particular ways of thinking supports and limits possibilities, and how engagement with alternative discursive spaces might produce the currently impossible or unintelligible.

The critical lens used during this thesis has produced a curious duality in relation to my professional world: feeling at times, that I am critiquing 'them' rather than 'us'. It is this tension as 'insider researcher' between the internal and external (accommodation and rejection), which has allowed me to 'see the familiar as strange' (Kuper, 2010; Kuper, 2013a), creating the freedom to critique inconsistencies and injustices. Similarly, this process of analysis has made me feel both more familiar with the professional field of

general practice medical education, through in-depth familiarity with the published research in this area, but also more distant through my engagement with critical analysis of general practice placement knowledge within research texts.

Limitations of the research process

While using a Foucauldian approach to discourse analysis has provided a number of fruitful and critical ways of interrogating these texts, it does, like any method, have its limitations.

I anticipate that many of my professional colleagues will be curious about the ways in which I have selected and analysed texts for this thesis. I cannot claim that this thesis is a comprehensive analysis of all the texts ever written about general practice placements, nor that someone else attempting this analysis would produce the same map of this discursive field. My initial searches to identify available texts were broad and will have included most available published texts in this field (no search strategy is ever perfect). My selection of texts to include in this thesis was interpretative. I established a deep familiarity with the texts through reading and re-reading papers, and re-visiting aspects of these in relation to other papers I subsequently read. I then began to iteratively select critical cases to develop my analysis. Analysis was not a process that I conducted, then wrote up, but something which emerged through iterations of categorising texts; making field notes; discussion with my supervisors; and writing drafts of analysis chapters.

A Foucauldian approach to discourse analysis produces challenges in terms of selecting and defining the 'boundaries' of texts to be analysed and determining the range of difference and coherence within a particular 'archive'. Foucault attempted to account for the *dispersed* nature of the elements and statements that make up discursive formations. His analyses, however, often describe or posit a singular, coherent and underlying *episteme* or 'archive' which define the total set of relations that unite discursive practices at the level of discursive regularities (Howarth, 2000, p. 63). Many identify a contradiction within this process, particularly if there are significant shifts or discontinuities over time (Howarth, 2000, p. 63). I hope, however, that I have been clear in the way that I set the boundaries for inclusion of texts which claimed to research general practice placements, then made visible, through my analysis, any inconsistencies and coherences within the boundaries of this discursive field.

In addition to the way in which texts were selected, I also anticipate some to be curious about my role as researcher in this analysis. Foucault wrote about the tension between the researcher's position as separate or integrated with the analytical process. He highlighted

how for Descartes, 'evidence' – the ability to identify, analyse, evaluate and extrapolate from relevant data – was all that was required to know 'the truth' (Schirato, 2012, p. 175):

> *"Before Descartes, one could not be impure, immoral, and know the truth. With Descartes we have a nonascetic subject of knowledge. This change makes possible the institutionalisation of modern science." (Foucault, 1997, p. 279)*

Foucault, however, challenges this idea and considers the integration of researcher and research products. He argues not only that the researcher shapes the research, but that the process of researching shapes the researcher – that, for example, critical thinking is the process we use to 'make' our subjectivity an object of self-reflexive thought (Schirato, 2012, p. 175). Criticism then becomes in this sense a:

> *"...historical investigation into the events that have led us to constitute ourselves and to recognise ourselves as subjects of what we are doing, thinking, saying." (Foucault, 1997, p. xxxv)*

In the same way that the texts I have analysed produce discursive practices, my own thesis and 'truth-telling' is contingent upon discursive practices and relations of power (Butler, 2005, p. 131). These texts concern my professional worlds of practice and research. My analysis and negotiation of these discursive practice 'rules', have been shaped, no doubt, by my multiple professional memberships and roles including being a GP, GP teacher, organiser of teaching and educational researcher. While others analysing these texts might readily reach production of a different discursive practice, I hope I have at least made clear within my analysis how I have identified particular components of the discursive field, and how I have related these to produce a particular perspective. Each time a particular analytical category emerged, I went back to the texts to refine these and ensure they made sense across the texts. Where they did not, this often stimulated further clarification of a category, or production of a contrasting category.

In chapter 6 I examine how subject positions are made available for the researcher: how rules produce possibilities for separation or integration of practitioner and researcher ways of knowing. I found this challenging to negotiate in my own writing for this thesis. Part of the purpose of this thesis was to help situate myself as a researcher in the discursive field of general practice medical education research. I have produced a map of 'the thinkable' which I hope will contribute to both my own and a broader reflexivity within the field. However, the

production of this map was conditional upon what I was able to see in relation to my own professional experience and perspectives. I have used the 'first person' to write about my rationale and sense-making of this thesis in the beginning and final chapters of this thesis. However, I have avoided using the first person in my analysis chapters. This was partly in an attempt to express this analysis as something relevant to the field, not only my own professional development and reflexivity. It also reflects the challenges I experienced during the analysis focusing my attention upon how meaning was produced within the research texts as a social practice. I have endeavoured to remain reflexive throughout my analysis, but realise that this fluctuation between language use is problematic in relation to some of the strategies discussed in the previous chapter.

There are also limitations in terms of the focus and 'product' of this analysis. I have chosen to write about this analysis within the constraints of *this* thesis, towards a *particular* purpose. Many have critiqued the work of Foucault for producing analyses towards a particular purpose, or focusing only upon particular concerns. While his work is at times 'historical', he does not claim to produce a comprehensive analysis of history, but rather focuses on particular aspects of that history. Some have, for example, critiqued the lack of attention within his work to feminist debates and issues (Butler, 2005). The focus of this thesis around tensions between general practice as a workplace and teaching space had not been planned from the outset, but emerged during the analysis, writing and tutorial discussions. This research is not claimed as a definitive or comprehensive account of the texts, but a contribution to debates – one analysis to address particular research questions, contingent upon the time, social context and a particular purpose of writing. At a different point in time, and perhaps with a different set of contextual constraints, this analysis might have produced a very different focus attending to a different set of issues.

This text is not a primary research text, but a secondary analysis of other research. It is not directly part of the discursive field analysed in this thesis, but is closely related. How, then, is this thesis positioned within the analysis of this thesis? I have situated this thesis within a social constructivist lens, which understands knowledge to be a socially constructed object. I have produced an analysis of this discursive field. I hope I have made clear the substance of the argument: how I have moved from data to an analytical category. While I hope that I have made visible the ways in which my analysis links to the texts, others might have read these texts differently from a different context, producing a different topography of this field. I have justified this research as producing new knowledge, using a new research methodology in the field of general practice medical education, and so treated my research

as innovative. I have sought not to evaluate, but make visible a discursive practice within this field. This has produced a researcher subject position for me, which requires me to reflexively make visible my experiential knowledge and how this has shaped my research. In my analysis, however, I have been careful not to use this experience to assume or claim meaning behind texts, but rather to attend to how meaning is produced within the text itself.

Having described my EdD journey: discovering sociological research and methodologies; reading Foucault; and undertaking assignments about competency-based assessment and a policy analysis highlighting the neoliberal ideologies shaping 'Tomorrow's Doctors', many of the analytical products of this thesis might seem predictable. The way in which I have categorised my analysis does, of course, draw on previous readings such as works by Foucault. Similarly, what I have been able to see as thinkable and unthinkable is limited to my own imagination and previous reading. The categories have, however, emerged iteratively through repeated analysis and reading of the texts. These have taken on numerous iterations - cycles of taking my analysis back to the texts - and it is not until this late stage in the analysis and writing, that I have a sense of clarity about how this thesis speaks to other literature and to a particular purpose.

I am reassured that I could not have predicted the map that this thesis has produced and while some aspects are perhaps unsurprising to me, others I could not have predicted and were not clear to me from the outset. The justification of research chapter, in particular, produced categories such as evaluation and hearing voices, which I had not previously considered. Although aware of some of the tensions between ways of characterising what is said to be taught and learnt in placements, I had not been able to articulate many of the differences, particularly how these produce such different subject positions and alignment with particular learning concepts. I have developed new insights about the different ways in which subject positions are produced for the researcher and how these relate to ways of knowing as a practitioner. While I have inevitably related this analysis to familiar ways of seeing and thinking, I have produced something unexpected, something new. This analysis has, then, provided me with much greater clarity and precision of understanding about general practice placement research texts, and how I might wish to engage with this field in future.

What next?

Many research theses make claims about the implications of the research findings. The purpose of this thesis is not to directly shape teaching practice, but rather to identify what is

currently thinkable in research texts as a step to discovering the unthinkable. Much of current research activity within medicine is orientated towards the application and utility of research findings, rather than production of 'blue skies research' (Hammersley, 2007). Even if research attempts to produce 'recommendations', there have been many problems associated with the 'translational gap' between the worlds of research and practice and 'application' of research findings (Lau, 2014). These debates have included attention to the nature of research as a 'meaningful problematisation' (Luhmann, 1990) or as a 'problem solving' activity (Roberts, 2003, p. 355). One focus of the translational gap debate has been the assumption that practitioners (positioned as research 'recipients') will be willing to change their practice based upon the production of 'scientific findings' or 'research evidence' (Bloor, 1997; Friedson, 1970).

Positioning myself as an 'insider researcher' is one way in which I have tried to approach the translational gap and link my professional context to my production of research questions and analysis. While connections between research and practice are unlikely to result in concrete application of findings, there are nuanced ways in which an insider researcher might inform debates and access forums from which to speak using, for example, knowledge of particular discursive practices or 'ways of seeing' to inform conversations with researchers and practitioners. This fluid movement between being an 'insider' and 'outsider' researcher has been challenging, using my experience to inform critical questions during analysis, while making the familiar strange and avoiding imposing my own expectations during the analytical process. Although initially reluctant to share my critique of this field with colleagues, I have found this analysis useful in shaping conversations about future research, particularly in my capacity as Chair of the SAPC educational research group.

Within Chapter 2, I discussed a distinction between sociologists' understandings of discourse, contrasting the work of Bourdieu and Foucault (Butler, 1999). This distinction was not only important in informing the analysis process, but also here concerning claims which might be made of the 'results'. For Foucault, meaning is realised textually. This analysis has produced a critical account of a discursive practice – this did not 'exist' before, but has been constructed through analysis of the texts. To what extent, then, can this sociological account inform or construct a future social reality? Determining the 'implications' of a Foucauldian approach to discourse analysis for social practices is problematic. Foucault opposed a teleological view to the analytical process, treating 'the point' of analysis as description of discursive regularities, with his later analyses also attending to the examination of how power relations are produced (Howarth, 2000, p. 56).

This analysis has made visible what is thinkable in research texts about general practice placements. I hope that it has raised some useful critical questions and begun to explore less visible, alternative ways of thinking which could shape ways in which general practice placement knowledge is constructed in future research texts. No 'way of thinking' is right or wrong, but a particular way of thinking will produce different possibilities for practice and available subject positions. This analytical lens helps make visible what is thinkable or possible to imagine and the power relations this produces within particular discursive practices. Foucault positions the subject as a *product* of discursive practices thereby minimising any sense of personal agency (Giddens, 1982). Hodges, however, describes the productive nature of being able to understand the ebbs and flow of power and develop the ability to move between different discursive practices as 'multidimensional thinkers' (Hodges, 2012, p. 41).

> *"What would be the value of the passion for knowledge if it resulted only in a certain amount of knowledgeableness and not, in one way or another and to the extent possible, in the knower's straying afield of himself? There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all....what is philosophy today .... if it is not the critical work that thought brings to bear on itself? In what does it consist, if not in the endeavour to know how and to what extent it might be possible to think differently, instead of legitimating what is already known?"*
> *(Foucault, 1985, pp. 8-9)*

A Foucauldian approach to discourse analysis facilitates a critical awareness of how particular discursive practices produce arguments about what is true/untrue, legitimate/illegitimate, permitted/forbidden in a given place and time (Hodges, 2012, p. 20). Through identifying 'the holes' in a discursive space, an analysis can inform future discussions, shifting repeated old arguments, stale turf battles and recurrent boundary disputes (Hodges, 2012, p. 40). Contrasting discursive practices can constrain thinking in different ways to produce different possible ends. Conducting an analysis can make it possible to see how different discursive practices shape a productive play of power in differing ways (Foucault, 1979a; Gordon, 1980). What I hope this thesis achieves is to map the possibilities of a discursive field, then draw out the impossible and unintelligible as a way of understanding the power relations produced and providing possibilities for thinking differently.

Appendix 1 – Search Strategies

Medline search strategy

1. Education, Medical, Undergraduate/
2. Students, Medical/
3. Curriculum/
4. Schools, Medical/
5. Family Practice/
6. General Practice/
7. Primary Health Care/
8. Community Medicine/
9. (general practi* or family practi* or (primary adj2 care) or primary health*).mp.
10. 1 or 2 or 3 or 4
11. 5 or 6 or 7 or 8 or 9
12. 10 and 11
13. exp africa/ or exp americas/ or antarctic regions/ or arctic regions/ or exp asia/ or exp australia/ or europe/ or andorra/ or austria/ or balkan peninsula/ or belgium/ or europe, eastern/ or finland/ or france/ or germany/ or gibraltar/ or greece/ or iceland/ or italy/ or liechtenstein/ or luxembourg/ or mediterranean region/ or monaco/ or netherlands/ or portugal/ or san marino/ or scandinavia/ or spain/ or switzerland/ or transcaucasia/ or vatican city/ or exp historical geographic locations/ or islands/ or atlantic islands/ or australia/ or borneo/ or greenland/ or indian ocean islands/ or indonesia/ or japan/ or macau/ or mediterranean islands/ or pacific islands/ or philippines/ or prince edward island/ or svalbard/ or taiwan/ or west indies/ or exp oceania/ or "exp oceans and seas"/
14. exp Great Britain/
15. Ireland/
16. 14 or 15
17. 13 and 16
18. 13 not 17
19. 12 not 18
20. limit 19 to english language

This search was run on 6 February 2013 from 1947 to the end of January 2013, and resulted in 16172 references.

Embase search strategy

1. *medical education/
2. medical student/
3. curriculum/
4. medical school/
5. (curricul* or undergraduate* or student*).af.
6. 1 or 2 or 3 or 4 or 5
7. general practice/
8. exp primary health care/
9. ambulatory care/
10. community medicine/
11. general practitioner/
12. (general practi* or family practi* or ambulatory care or (primary adj2 care) or primary health*).af. or community.ti.
13. 7 or 8 or 9 or 10 or 11 or 12
14. 6 and 13
15. limit 14 to embase

This was run on 6 February 2013 from 1980 to the end of January 2013, and resulted in 16343 references before deduplication.

PsycINFO search strategy

1. medical education/
2. medical students/
3. curriculum/
4. family medicine/
5. primary health care/
6. outpatient treatment/
7. general practitioners/
8. family physicians/
9. (curricul* or undergraduate* or student*).mp.
10. (general practi* or family practi* or ambulatory care or (primary adj2 care) or primary health*).mp. or community.ti.
11. 1 or 2 or 3 or 9
12. 4 or 5 or 6 or 7 or 8 or 10

13. 11 and 12

This was run on 13 February 2013 from 1806 to the end of January 2013, and resulted in 8782 references before deduplication.

Educational databases search strategy

S4	SU.EXACT.EXPLODE("Medical students") OR SU.EXACT.EXPLODE("Graduate medical students") OR SU.EXACT("Medical education") OR SU.EXACT.EXPLODE("Graduate medical education")	Australian Education Index, British Education Index, ERIC	63571
S5	SU.EXACT("Family practice (Medicine)") OR SU.EXACT.EXPLODE("Primary health care") OR SU.EXACT("Community health services")	Australian Education Index, British Education Index, ERIC	3806
S6	curricul* or undergraduate* or student*	Australian Education Index, British Education Index, ERIC	875583
S7	s4 or s6	Australian Education Index, British Education Index, ERIC	916428
S8	"general practi*" or "family practi*" or "ambulatory care" or (primary pre/2 care) or "primary health*" or (community pre/2 health)	Australian Education Index, British Education Index, ERIC	8075
S9	s5 or s8	Australian Education Index, British Education Index, ERIC	8599
S10	s7 and s9	Australian Education Index, British Education Index, ERIC	3835
S17	SU.EXACT("General Practice (Medicine)")	Australian Education Index, British Education Index, ERIC	204

S19	s10 or s17	Australian Education Index, British Education Index, ERIC	3907
S20	SU.EXACT("General Practice (Medicine)")	Australian Education Index, British Education Index, ERIC	204
S21	s20 not s19	Australian Education Index, British Education Index, ERIC	191

Searches on the educational databases were run on 11 Feb and resulted in the following citation results:

- ERIC (3092)
- Australian Education Index (342)
- British Education Index (498) – plus an additional 191 from a subsequent broader search including everything indexed with the term “General Practice (Medicine)” – which is unique to BEI.

CINAHL search strategy

#	Query
S15	S13 AND S14
S14	S8 OR S9 OR S10 OR S11 OR S12
S13	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7
S12	TX curricul* or undergraduate* or student*
S11	(MH "Schools, Medical")
S10	(MH "Curriculum+")
S9	(MH "Students, Medical")
S8	(MH "Education, Medical")
S7	TI community
S6	TX general practi* or family practi* or ambulatory care or (primary n2 care) or primary health*

S5	(MH "Physicians, Family")
S4	(MH "Community Medicine")
S3	(MH "Ambulatory Care")
S2	(MH "Primary Health Care")
S1	(MH "Family Practice")

This was run on 13 February 2013 from 1937, and resulted in 9758 references before deduplication

Index to Theses

Separate one-line searches were carried out as follows:

(curricul* or undergraduate* or student*) AND ("family practi*")
-retrieving 48 references

(curricul* or undergraduate* or student*) AND ("primary health*")
-retrieving 15 references

(curricul* or undergraduate* or student*) AND (ti contains community)
-retrieving 176 references

ProQuest Dissertations and Theses

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all(("general practi*" OR "family practi*" OR "ambulatory care" OR (primary
PRE/2 care) OR "primary health*" OR (community PRE/2 health))) AND
all(curricul* OR undergraduate* OR student*)
```
-retrieved 815 references

Appendix 2 - Research texts about undergraduate medical education in the UK general practice setting

These were the texts from which I constructed my archive, beginning my analysis and production of a discursive field of research texts about undergraduate general practice placements. I used an initial, then iterative process of familiarisation, ensuring I selected a range of texts across various years of publication; range of journal of publication; and range of authors. I began to read and re-read these texts, selecting critical cases and counter-cases to build my archive.

Title	Journal	Author	Year
Medical students and general practice.	Lancet	Pearson R J	1968
The undergraduate curriculum in retrospect	Britj.Med.Educ.	McAndrew G M	1970
Medical students' response to undergraduate instruction in general practice.	British journal of medical education	Dean T M	1971
A teaching course in general practice	BRIT.J.MED.EDUC.	Barber J H	1973
Practical work in epidemiology and community medicine for medical undergraduates	International Journal of Epidemiology	Pemberton J	1973
University departments of general practice and the undergraduate teaching of general practice in the United Kingdom in 1972.	The Journal of the Royal College of General Practitioners	Byrne P S	1973
Patients' attitudes to medical students in general practice	British Medical Journal	Wright H J	1974
Development and evaluation of teaching course in general practice	BRIT.J.MED.EDUC.	Barber J H	1975
Medical sociology in Great Britain.	British journal of medical education	Maclean U	1975
Computer-assisted learning in undergraduate medical teaching.	Lancet	Murray T S	1976
British medical undergraduates in 1975: A student survey in 1975 compared with 1966	MED.EDUC.	Donnan S P.B	1976
Attitudes towards the content of general practice teaching	MED.EDUC.	Hannay D R	1976
A comparative study of teachers' attitudes in the teaching of undergraduate medical students	MED.EDUC.	Harvard Davis R	1976
Constructing a new course for undergraduate teaching of general practice.	Medical education	Irwin W G	1976
Using the first consultation in acute illness for	The Journal of the	Murray T	1976

teaching third year medical students.	Royal College of General Practitioners	S	
Introduction of recording booklets in general practice teaching	Medical Education	Murray T S	1977
Medical undergraduate teaching of paediatrics in the community.	Medical education	Murray T S	1977
Characteristics of senior medical students at Belfast	Medical Education	Irwin W G	1978
An evaluation of a course for undergraduate teaching of general practice	Medical Education	Irwin W G	1978
Attitudes of medical undergraduates in Glasgow to computer-assisted learning	Medical Education	Murray T S	1978
Teaching communication skills to pre-clinical medical students: a general practice based approach	Medical Education	Armstrong D	1979
Patients' reactions to a two-way mirror in general practice	Medical Education	Elliott B	1979
Attitudes of medical undergraduates in Glasgow to computer-assisted learning	Medical Education	Murray T S	1979
Student experience in family medicine at McMaster and Glasgow Universities.	Medical education	Hannay D R	1980
Teachers in general practice: A comparative study	Medical Education	Hay J	1980
The way we teach ... general practice	Medical Teacher	Marinker Marshall	1980
Medical student attitudes and general practice.	The Journal of the Royal College of General Practitioners	Fowler G H	1980
Integrating general practice tutors into an undergraduate programme	Medical Education	Carson N E	1981
'Do as I say and not as I do'? An audit of clinical management in teaching compared with service work	Medical Education	Freeman G K	1981
Systematic use of closed-circuit television in a general practice teaching unit.	The Journal of the Royal College of General Practitioners	Irwin W G	1981
Objectives and students' learning in general practice	Medical Education	Freeling P	1982
Integrated medical student teaching. A combined course in community medicine, general practice, geriatric medicine and mental health	Medical Education	Stout R W	1982
Consumer views on the medical curriculum: A retrospective study of Aberdeen graduates	Medical Education	Richardson I M	1983
The place of primary health care in medical education in the United Kingdom: a survey	Medical Education	Walton H J	1983
Undergraduate learning in general practice: the views of 1,000 final-year students.	The Journal of the Royal College of General Practitioners	Richardson I M	1983
A modified essay question evaluation of pre-clinical teaching of communication skills.	Medical education	Weinman J	1984
The effects of Southampton's community experiences on student learning.	Medical education	Coles C R	1985

Primary health care in European medical education: A survey	Medical Education	Walton H J	1985
General practice in the context of an undergraduate course in behavioural sciences.	Medical teacher	Mason C	1985
Medical students' beliefs about nine different specialties.	British medical journal (Clinical research ed.)	Furnham A F	1986
Research in epidemiology and community health in the medical curriculum: students' opinions of the Nottingham experience.	Journal of epidemiology and community health	Elwood J M	1986
Medical students with personal problems--can departments of general practice help?.	Medical teacher	Dowell A C	1989
Medical student experience of London general practice teaching attachments.	Medical education	Schamroth A J	1990
Teaching problem handling in general practice: a computer assisted learning software package for medical students.	The British journal of general practice : the journal of the Royal College of General Practitioners	Stanley I	1991
The contribution of general practice to medical education: Expectations and fulfilment.	British Journal of Medical Education	Lloyd M H	1992
Audit in general practice: students and practitioners learning together.	Quality in health care : QHC	Campion P	1992
What do medical students seek to learn from general practice? A study of personal learning objectives.	The British journal of general practice : the journal of the Royal College of General Practitioners	Stanley I M	1992
Undergraduate teaching in dermatology and general practice [9]	British Journal of Dermatology	Hay R J	1993
Audit: Teaching medical students in general practice	Medical Education	Morrison J M	1993
Teaching clinical methods to medical students	Medical Education	Oswald N T.A	1993
Subjective and behavioural evaluation of the teaching of patient interview skills.	Medical education	Usherwood T	1993
Evaluation of a rule base for decision making in general practice	British Journal of General Practice	Essex B	1994
Medical graduates evaluate the effectiveness of their education.	British Journal of Medical Education	Clack Gillian B	1994
Teaching student-centred educational approaches to general practice teachers.	British Journal of Medical Education	Coles C R	1994
An experiment in problem-based learning.	British Journal of Medical Education	Morrison J M	1994
Contribution of academic departments of general practice to undergraduate teaching, and their plans for curriculum development.	The British journal of general practice : the journal of the Royal College of General Practitioners	Robinson L A	1994
How do academic heads of departments of general practice organize patient care? A European survey	British Journal of General Practice	Himmel W	1995

Competence-based summative assessment of a student-directed course: Involvement of key stakeholders.	British Journal of Medical Education	Usherwood Tim	1995
Structured packs for independent learning in the community	Medical Education	Graham H J	1995
Community-based medical education: Feasibility and cost	Medical Education	Murray E	1995
Attitudes of patients to medical student participation: General practice consultations on the Cambridge Community-Based Clinical Course.	British Journal of Medical Education	Jones Steve	1996
Teaching the teachers - A needs assessment of tutors for a new clinical skills course	Medical Education	Robinson L A	1996
General practice and medical education: What do medical students value?	Medical Teacher	Snadden D	1996
Medical students in general practice: how do patients feel?.	The British journal of general practice : the journal of the Royal College of General Practitioners	Cooke F	1996
Career preferences of medical students: influence of a new four-week attachment in general practice.	The British journal of general practice : the journal of the Royal College of General Practitioners	Morrison J M	1996
Undergraduate teaching in the community: can general practice deliver?.	The British journal of general practice : the journal of the Royal College of General Practitioners	Wilson A	1996
Can students learn clinical method in general practice? A randomised crossover trial based on objective structured clinical examinations.	BMJ (Clinical research ed.)	Murray E	1997
Consent and confidentiality in teaching in general practice: Survey of patients' views on presence of students	British Medical Journal	O'Flynn N	1997
Community hospitals and general practice: Extended attachments for medical students	Medical Education	Grant J	1997
Can general internal medicine be taught in general practice? An evaluation of the University College London model	Medical Education	Murray E	1997
Acquisition of basic clinical skills in the general practice setting	Medical Education	Parle J V	1997
General practitioner teaching in the community: a study of their teaching experience and interest in undergraduate teaching in the future.	The British journal of general practice : the journal of the Royal College of General Practitioners	Gray J	1997
Learning medicine in the community.	Academic medicine : journal of the Association of American Medical Colleges	Bonsor R	1998

Providing early clinical experience in primary care.	British Journal of Medical Education	Hampshire A J	1998
Students' perceptions of a learner-centred approach using problem-based learning on an undergraduate general practice course at the University of Manchester	Medical Teacher	Warburton Beverly	1998
Influence on general practitioners of teaching undergraduates: qualitative study of London general practitioner teachers.	BMJ (Clinical research ed.)	Hartley S	1999
Experiences with "rapid appraisal" in primary care: involving the public in assessing health needs, orientating staff, and educating medical students.	BMJ (Clinical research ed.)	Murray S A	1999
Structured packs for independent learning: A comparison of learning outcome and acceptability with conventional teaching.	British Journal of Medical Education	Graham H J	1999
Clinical experience of medical students in primary care: Use of an electronic log in monitoring experience and in guiding education in the Cambridge Community Based Clinical Course	Medical Education	Alderson T St.J	1999
Students conducting consultations in general practice and the acceptability to patients	Medical Education	Bentham J R	1999
Community-oriented medical education in Glasgow: Developing a community diagnosis exercise	Medical Education	Davison H	1999
A comparison of the educational opportunities on junior medical attachments in general practice and in a teaching hospital: A questionnaire survey	Medical Education	Murray E	1999
Extending community involvement in the medical curriculum: Lessons from a case study	Medical Education	Seabrook M A	1999
Patient-centred consultations: a comparison of student experience and understanding in two clinical environments.	Medical education	Thistlethwaite J E	1999
Audit encourages an evidence-based approach to medical practice	Medical Education	Wainwright J R	1999
Single-handed practices - Their contribution to an undergraduate teaching network in the first year of the new curriculum	Medical Education	Wylie A M	1999
Are we going in the right direction? A survey of the undergraduate medical education in Canada, Australia and the United Kingdom from a general practice perspective	Medical Teacher	Elliott M K	1999
Seven years' experience of continuous assessment for degree examination in general practice	Medical Teacher	Hannay D R	1999
Introducing medical students to the concept of patient-centred consultations during a community-based teaching attachment	Medical Teacher	Thistlethwaite J E	1999
Does teaching during a general practice consultation affect patient care?.	The British journal of general practice : the	O'Flynn N	1999

	journal of the Royal College of General Practitioners		
Basic clinical skills: Don't leave teaching to the teaching hospitals.	British Journal of Medical Education	Johnston B T	2000
Introducing community-based teaching of third year medical students: Outcomes of a pilot project one year later and implications for managing change	Education for Health	Thistlethwaite J E	2000
Linking general practices to the medical schools: Qualitative issues	Medical Education	Gray R W	2000
Student perceptions of a new integrated course in clinical methods for medical undergraduates	Medical Education	Hastings A M	2000
Teaching in practice: A qualitative factor analysis of community-based teaching	Medical Education	Howe A	2000
Formative assessment of the consultation performance of medical students in the setting of general practice using a modified version of the Leicester Assessment Package	Medical Education	McKinley R K	2000
Students' perceptions of the relative advantages and disadvantages of community-based and hospital-based teaching: A qualitative study	Medical Education	O'Sullivan M	2000
First step: Report on a pilot course for personal and professional development	Medical Education	Thistlethwaite J E	2000
The University Linked Practices computer network project in East London and Essex: A qualitative evaluation	Medical Teacher	Gray R W	2000
Mapping teaching and research activity in general practice	Medical Teacher	Gray Selena	2000
Can Nurses Teach Tomorrow's Doctors? A Nursing Perspective on Involvement in Community-Based Medical Education.	Medical Teacher	Howe Amanda	2000
Not so easy as it sounds: A qualitative study of a shared learning project between medical and nursing undergraduate students	Medical Teacher	Roberts C	2000
Undergraduate rheumatology teaching in the UK: A survey of current practice and changes since 1990	Rheumatology	Kay L J	2000
Using real patients in problem-based learning: Students' comments on the value of using real, as opposed to paper cases, in a problem-based learning module in general practice	Medical Education	Dammers J	2001
What can students learn from studying medicine in literature?	Medical Education	Hampshire A J	2001
Does community-based experience alter career preference? New evidence from a prospective longitudinal cohort study of undergraduate medical students	Medical Education	Howe A	2001
Patient-centred medicine through student-	Medical education	Howe A	2001

centred teaching: a student perspective on the key impacts of community- based learning in undergraduate medical education.			
What do students actually do on an internal medicine clerkship? A log diary study	Medical Education	Murray E	2001
Designing a community-based fourth-year obstetrics and gynaecology module: an example of innovative curriculum development.	Medical education	Nicholson S	2001
Evaluating primary care as a base for medical education: The report of the Cambridge community-based clinical course	Medical Education	Oswald N	2001
Students' conceptual model of a good community attachment	Medical Education	Silverstone Z	2001
CeMENT: evaluation of a regional development programme integrating hospital and general practice clinical teaching for medical undergraduates. The Community-Based Medical Education in North Thames.	Medical education	Wallace P	2001
Community-orientated medical education: Extending the boundaries	Medical Teacher	Cooper H C	2001
More than just a shopkeeper: Involving the community pharmacist in undergraduate medical education	Medical Teacher	Owens P	2001
Characteristics of general practices involved in undergraduate medical teaching.	The British journal of general practice : the journal of the Royal College of General Practitioners	Gray R W	2001
Clinical governance and education: The views of clinical governance leads in the South West of England	British Journal of Clinical Governance	Clark C E	2002
Teaching dermatology to medical students: A survey of current practice in the U.K	British Journal of Dermatology	Burge S	2002
Attitude of medical students towards general practice and general practitioners	British Journal of General Practice	Henderson E	2002
General practitioners' experience of teaching a community course to undergraduate medical students: A qualitative study	Education for Primary Care	Lammie S	2002
The challenge of being a community tutor on the Manchester Medical Undergraduate Degree Programme	Education for Primary Care	Sandars John	2002
Patients' views and feelings on the community-based teaching of undergraduate medical students: a qualitative study.	Family practice	Coleman Katie	2002
'Walking in the moccasins...'. Extending the boundaries of undergraduate medical education	Journal of Interprofessional Care	Brown L	2002
In our own image--a multidisciplinary qualitative analysis of medical education.	Journal of interprofessional care	Howe Amanda	2002
Helping tomorrow's doctors to gain a population health perspective - good news for community stakeholders.	Medical education	Howe Amanda	2002

Development of transferable skills during short special study modules: students' self-appraisal.	Medical teacher	Jha Vikram	2002
The CeMENT project: a case study in change management	Medical Teacher	Macfarlane Fraser	2002
Student access and use of IT during general practice attachments	Medical Teacher	Regan Maria A	2002
Teaching as therapy: cross sectional and qualitative evaluation of patients' experiences of undergraduate psychiatry teaching in the community.	BMJ (Clinical research ed.)	Walters Kate	2003
Teaching as therapy: cross sectional and qualitative evaluation of patients' experiences of undergraduate psychiatry teaching in the community.	BMJ: British Medical Journal (International Edition)	Walters K	2003
Medical students' orientation towards rural general practice: results from an exploratory study of a Scottish cohort.	Education for Primary Care	Farmer J	2003
An example of interprofessional teaching in the community for final-year medical students: challenges and rewards.	Education for Primary Care	Lempp H	2003
Developing communication skills: A selected study module for first-year medical students using an educational constructivist approach	Education for Primary Care	Nicholson S	2003
Developing 'the good healthcare practitioner': clues from a study in medical education.	Learning in Health & Social Care	Duncan P	2003
Clinical exposure during clinical method attachments in general practice.	Medical education	Bryant Pauline	2003
Conflict and coping strategies: a qualitative study of student attitudes to significant event analysis.	Medical education	Henderson Emma	2003
The development and evaluation of a community attachment scheme for first-year medical students	Medical Teacher	Hannay David	2003
Doctors becoming GPs: GP registrars' experience of medical training and motivations for going into general practice	Education for Primary Care	Lucas H	2004
The views of general practitioner tutors on developing medical students' communication and management skills	Education for Primary Care	Thistlethwaite J	2004
What impact will an increased number of teaching general practices have on patients, doctors and medical students?.	Medical education	Mathers Jonathan	2004
Clinical placements for medical students: factors affecting patients' involvement in medical education	Medical Teacher	Chipp Elizabeth	2004
The relationship between measures of patient satisfaction and enablement and professional assessments of consultation competence.	Medical teacher	McKinley R K	2004
Regional Examination of the Musculoskeletal System (REMS): a core set of clinical skills for medical students.	Rheumatology (Oxford, England)	Coady D	2004

Teaching medical students musculoskeletal examination skills: identifying barriers to learning and ways of overcoming them.	Scandinavian journal of rheumatology	Coady D A	2004
Impact on patients of expanded, general practice based, student teaching: Observational and qualitative study	British Medical Journal	Benson J	2005
Learning medicine in primary care: medical students' perceptions of final-year clinical placements.	Education for Primary Care	Lucas B	2005
Maintaining the quality of community-based education: an evaluation of an innovative, centralised system for giving student feedback to undergraduate general practice tutors.	Education for Primary Care	Nicholson S	2005
Putting double marking to the test: a framework to assess if it is worth the trouble.	Medical education	Cannings Rebecca	2005
It isn't just consultants that need a BSc: student experiences of an Intercalated BSc in primary health care.	Medical teacher	Jones M	2005
Geriatric medicine training in UK undergraduate medical schools	Reviews in Clinical Gerontology	Bartram L	2005
Learning to mark: a qualitative study of the experiences and concerns of medical markers.	BMC medical education	Hawthorn e Kamila	2006
Strengths and weaknesses in the consultation skills of senior medical students: Identification, enhancement and curricular change.	British Journal of Medical Education	Hastings A M	2006
Clinical clerkships: Students can structure their own learning.	British Journal of Medical Education	Smith Pat	2006
How can GP teachers be supported to make good teaching even better?	Education for Primary Care	Cook V	2006
Patients' attitudes towards the presence of medical students during consultations.	Medical teacher	Choudhur y Tawfiqur Rahman	2006
Introducing undergraduate medical teaching into general practice: an action research study	Medical Teacher	Grant Andy	2006
Teaching evidence-based medicine to undergraduate medical students: A course integrating ethics, audit, management and clinical epidemiology	Medical Teacher	Rhodes M	2006
A future career in general practice? A longitudinal study of medical students and pre-registration house officers.	The European journal of general practice	Sinclair Hazel K	2006
Exploring students' perceptions on the use of significant event analysis, as part of a portfolio assessment process in general practice, as a tool for learning how to use reflection in learning	BMC Medical Education	Grant A J	2007
Using problem-based learning in primary care: What do undergraduates on traditional medical courses make of it?	Education for Primary Care	Darnton R	2007

Medical students' perceptions of primary care: the influence of tutors, peers and the curriculum.	Education for Primary Care	Firth A	2007
The impact of expanded general practice-based student teaching: the practices' story.	Education for Primary Care	Quince T	2007
Is primary care 'real' medicine? Some medical students appear to think not.	Medical education	Jones Ellen	2007
Teaching undergraduate psychiatry in primary care: the impact on student learning and attitudes.	Medical education	Walters Kate	2007
A survey of UK medical schools' arrangements for early patient contact.	Medical teacher	Hopayian Kevork	2007
Patient contact in the first year of basic medical training - Feasible, educational, acceptable?	Medical Teacher	Howe A	2007
Undergraduate allergy teaching in a UK medical school: Comparison of the described and delivered curriculum	Primary Care Respiratory Journal	Shehata Y	2007
Medical students' views about an undergraduate curriculum in psychiatry before and after clinical placements.	BMC medical education	Oakley Clare	2008
Is it me or is it them? Factors that influence the passing of underperforming students.	British Journal of Medical Education	Cleland Jennifer A	2008
Thinking 'no' but saying 'yes' to student presence in general practice consultations: Politeness theory insights.	British Journal of Medical Education	Rees Charlotte E	2008
A comparison of clinical content between structured specialty teaching sessions and teaching in routine general practice consultations.	Education for Primary Care	Bryant P	2008
A qualitative study of medical students' attitudes to careers in general practice.	Education for Primary Care	Edgcumbe DP	2008
Do medical students want a career in general practice? A rich mix of influences!.	Education for Primary Care	Hogg R	2008
Quality assurance of community based undergraduate medical curricula: a cross-sectional survey.	Education for Primary Care	Jones R	2008
Do medical students learn about general practice outside working hours? An audit of UK medical schools.	Education for Primary Care	Owen S	2008
The effect of gender on medical students' aspirations: A qualitative study	Medical Education	Drinkwater J	2008
Enhancing student reflection: The development of an e-portfolio	Medical Education	Pink J	2008
Does the presence of medical students affect quality in general practice consultations?	Medical Education	Price Richard	2008
Undergraduate research in primary care: Is it sustainable?	Primary Health Care Research and Development	Jones Melvyn	2008
Evidence for the acceptability and academic success of an innovative remote and rural extended placement.	Rural and remote health	Wilson Morven	2008

Lost in translation: Using bilingual simulated patients to improve consulting across language barriers	Education for Primary Care	Escott S	2009
Developing a new GP placement for medical students: The Shetland experience	Education for Primary Care	McNiff C	2009
Developing a set of quality criteria for community-based medical education in the UK.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Cotton Philip	2009
Do visits help improve the quality of teaching within undergraduate teaching practices?.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Elam Paul	2009
Medical curricula and preventing childhood obesity: pooling the resources of medical students and primary care to inform curricula.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Wylie Ann	2009
Early clinical exposure in medical curricula across Europe: An overview	European Journal of General Practice	Basak O	2009
The Effect of the Presence of a Medical Student on the Quality of the Doctor-Patient Interaction	Family Medicine	Price R	2009
'Can you take a student this morning?' Maximising effective teaching by practice nurses.	Medical education	Smith Pat	2009
'They've all got to learn'. Medical students' learning from patients in ambulatory (outpatient and general practice) consultations.	Medical Teacher	Ashley Philippa	2009
Mapping the work-based learning of novice teachers: charting some rich terrain.	Medical teacher	Cook Vivien	2009
Evaluation of different delivery modes of an interactive e-learning programme for teaching cultural diversity.	Patient education and counseling	Hawthorne Kamila	2009
Perceptions of UK medical students on rural clinical placements.	Rural and remote health	Deaville Jenny A	2009
Medical students' perceptions of general practice as a career choice.	Education for Primary Care	Merriman R	2010

Some effects of teaching undergraduate medical students on general practitioner thinking and learning.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Grant Andrew	2010
A survey of general practitioners' opinions and perceived competencies in teaching undergraduate psychiatry.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Thompson Catherine	2010
Medical professionalism: Conflicting values for tomorrow's doctors.	Journal of General Internal Medicine	Borgstrom Erica	2010
Medical students' and prospective medical students' uncertainties about career intentions: cross-sectional and longitudinal studies.	Medical teacher	Maudsley Gillian	2010
Undergraduate learning.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Anonymous	2011
GP registrars as teachers: a survey of their level of involvement and training.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Halestrap Peter	2011
Passing standards for undergraduate primary care examinations at UK medical schools.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Hancock Julian	2011
Joint undergraduate and postgraduate practice visits: a pilot in southwest England.	Education for primary care : an official	Harding Alex	2011

	publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors		
What are the key elements of a primary care teaching practice?.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Pearson David	2011
How we created virtual patient cases for primary care-based learning.	Medical Teacher	Adams E C	2011
Overcoming the pull factor of convenient urban living - perceptions of rural general practice placements	Medical Teacher	Deaville Jennifer	2011
A virtual surgery in general practice: Evaluation of a novel undergraduate virtual patient learning package.	Medical Teacher	Gormley Gerard J	2011
Engagement and opportunity in clinical learning: Findings from a case study in primary care.	Medical Teacher	Pearson David J	2011
Foundation Programme doctors as teachers.	The clinical teacher	Nagel Catie	2011
Manchester Clinical Placement Index (MCPI). Conditions for Medical Students' Learning in Hospital and Community Placements	Advances in Health Sciences Education	Dornan Tim	2012
Phenomenological analysis of patient experiences of medical student teaching encounters.	British Journal of Medical Education	McLachlan Emma	2012
Clinical ear, nose and throat training as a percentage of the undergraduate medical curriculum	Clinical Otolaryngology	Davies K L	2012
Patient perceptions of their role in undergraduate medical education within a primary care teaching practice.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Lucas Beverley	2012
Intercalated degrees in primary care: luxury, folly or core business for medical schools?.	Education for primary care : an official publication of the Association of Course Organisers, National	Toft Kristan	2012

	Association of GP Tutors, World Organisation of Family Doctors		
An evaluation of the impact of an increase in community-based medical undergraduate education in a UK medical school.	Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors	Watmough Simon	2012
Teaching about medically unexplained symptoms at medical schools in the United Kingdom	Medical Teacher	Howman Mary	2012

Appendix 3 – Ethics UCL

This is very helpful - thank you.
BW
Sophie

From: GradSch.Ethics
Sent: 03 July 2012 11:25
To: Park, Sophie
Subject: RE: ethics approval
Yes, it will be exempt.
Helen

Helen Dougal
Ethics Committee Administrator
UCL Graduate School
Ex. 37844

From: Park, Sophie
Sent: 03 July 2012 11:02
To: GradSch.Ethics
Subject: RE: ethics approval
Many thanks Helen - most grateful.
Could I also take this opportunity to ask about another study?

I am conducting a Foucauldian Discourse Analysis of research literature about undergraduate medical education in the general practice setting for completion of my doctoral thesis. This will be using secondary data. This will be published data. I may or may not need to use some 'grey' literature e.g. thesis documents or curriculum documents for this, but no primary participant data will be involved. The planned start time for this project is October 2012.

Could I please confirm with you that as these studies are an evaluation of existing literature (the majority of which is already published) that this will be exempt from further ethical approval applications, or will you require a formal application?

Many thanks for your help and BW

Sophie

Sophie Park MBChB M.Med.Sci (dist) MRCGP (dist) DCH DFFP

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Research Dept. of Primary Care and Population Health

UCL Medical School

Hampstead Campus

Rowland Hill St.

London NW3

Tel: 07967 229421

Appendix 4 – Constructing my archive

These were the texts I used to construct my archive, from which I selected statements (using iterative critical case selection) to conduct my analysis. Some of the statements from this archive are included as instances or examples in this thesis.

The columns outline the paper's title, journal, author, year of publication, and whether or not I am professionally acquainted with one or more of the authors. The second table contains brief information about each journal and its audience – information which is helpful for understanding both my sampling of a range of texts, as well as any genealogical shifts in the location of publications about this topic. The third table presents table 1 data, but divided into different categories of journal (and therefore audience).

Table 5: Constructing my archive

Title	Journal	Author(s)	Year	Known?
A teaching course in general practice	BRIT.J.MED.EDUC.	Barber, J.	1973	
Patients' attitudes to medical students in general practice	British Medical Journal	Wright, H.	1974	
Computer-assisted learning in undergraduate medical teaching.	Lancet	Murray, T., Barber, J., and Hannah, D.	1976	
Attitudes of medical undergraduates in Glasgow to computer-assisted learning	Medical Education	Murray, T., Barber, J., and Dunn, W.	1978	
Teaching communication skills to pre-clinical medical students: a general practice based approach	Medical Education	Armstrong, D., Hicks, B., Higgins, P., and Weinman, J.	1979	
Medical student attitudes and general practice.	The Journal of the Royal College of General Practitioners	Fowler G H	1980	
Student experience in family medicine at McMaster and Glasgow Universities.	Medical education	Hannay, D R	1980	
'Do as I say and not as I do'? An audit of clinical management in teaching compared with service work	Medical Education	Freeman G K	1981	
The patient is the expert: a technique	Medical education	Kent, G.,	1981	

for teaching interviewing skills		Clarke, P., and Dalrymple-Smith, D.		
An evaluation of medical student behaviours in communication	Medical Education	Irwin,W. and Bamber, J.	1984	
The effects of Southampton's community experiences on student learning.	Medical education	Coles, C.	1985	
General practice in the undergraduate curriculum: 20 interviews with Southampton final-year students	Medical Education	Mattson, B., Freeman, G., Coles, C., and Schmedlin, J.	1991	*
Undergraduate teaching in dermatology and general practice [9]	British Journal of Dermatology	Hay, R.	1993	
The contribution of general practice to medical education: Expectations and fulfilment.	British Journal of Medical Education	Lloyd, M. and Rosenthal, J.	1992	*
Early patient contact for medical students: an exploration of GP teachers' perceptions	Medical Teacher	Mowat, D. and Hudson, H.	1996	
Undergraduate teaching in the community: can general practice deliver?.	The British journal of general practice	Wilson, A., Fraser, R., McKinley, R., Preston-Whyte, E., and Wynn, A.	1996	
General practitioner teaching in the community: a study of their teaching experience and interest in undergraduate teaching in the future.	The British journal of general practice	Gray, J. and Fine, B.	1997	
Can students learn clinical method in general practice? A randomised crossover trial based on objective structured clinical examinations.	BMJ (Clinical research ed.)	Murray, E., Jolly, B., and Modell, M.	1997	*
Community hospitals and general practice: extended attachments for medical students	Medical Education	Grant, J., Ramsay, A., and Bain, J.	1997	
Providing early clinical experience in primary care.	British Journal of Medical Education	Hampshire, A.	1998	*
A comparison of the educational opportunities on junior medical attachments in general practice and in a teaching hosptial: A questionnaire survey	Medical Education	Murray, E., Jolly, B. and Modell, M.	1999	*
Community-oriented medical education in Glasgow: Developing a community diagnosis exercise	Medical Education	Davison, H., Capewell, S., Macnaughto	1999	

		n, J., Murray, S., Hanlon, P., and McEwan, J.		
Influence on general practitioners of teaching undergraduates: qualitative study of London general practitioner teachers.	BMJ (Clinical research ed.)	Hartley, S., Macfarlane, F., Gantley, M., and Murray, E.	1999	*
Patient-centred consultations: a comparison of student experience and understanding in two clinical environments	Medical Education	Thistlethwaite, J. E., and Jordan, J.	1999	
Basic clinical skills: Don't leave teaching to the teaching hospitals.	British Journal of Medical Education	Johnston, B., and Boohan, M.	2000	
Students' perceptions of the relative advantages and disadvantages of community-based and hospital-based teaching: A qualitative study	Medical Education	O'Sullivan, M., Martin, J., and Murray, E.	2000	*
Using real patients in problem-based learning: Students' comments on the value of using real, as opposed to paper cases, in a problem-based learning module in general practice	Medical Education	Dammers, J., Spencer, J., and Thomas, M.	2001	*
Students' conceptual model of a good community attachment	Medical Education	Silverstone, Z., Whitehouse, C., Willis, S., McArdle, P., Jones, A., and O'Neill, P.	2001	
Attitude of medical students towards general practice and general practitioners	British Journal of General Practice	Henderson, E., Berlin, A., and Fuller, J.	2002	*
Student access and use of IT during general practice attachments	Medical Teacher	Regan, M., O'Neill, P., and Whitehouse, C.	2002	
Developing communication skills: A selected study module for first-year medical students using an educational constructivist approach	Education for Primary Care	Nicholson, S., Rana-Masson, S., and Cushing, A.	2003	*
Impact on patients of expanded, general practice based, student teaching: Observational and	British Medical Journal	Benson, J., Hibble, A., Fanshawe,	2005	*

qualitative study		T., and Emery, J.		
Clinical clerkships: Students can structure their own learning.	British Journal of Medical Education	Smith, P., and Morrison, J.	2006	
Is primary care 'real' medicine? Some medical students appear to think not.	Medical education	Jones, E., and Helbren, E.	2007	
The impact of expanded general practice-based student teaching: the practices' story.	Education for Primary Care	Quince, T., Benson, J., Hibble, A., and Emery, J.	2007	*
Teaching undergraduate psychiatry in primary care: the impact on student learning and attitudes.	Medical education	Walters, K., Raven, P., Rosenthal, J., Russell, J., Humphrey, C., and Buszewicz, M.	2007	*
A comparison of clinical content between structured specialty teaching sessions and teaching in routine general practice consultations.	Education for Primary Care	Bryant, P., Berlin, A., Coppola, W., and Jones, M.	2008	*
Does the presence of medical students affect quality in general practice consultations?	Medical Education	Price, R., Spencer, J., and Walker, J.	2008	*
Thinking 'no' but saying 'yes' to student presence in general practice consultations: Politeness theory insights.	British Journal of Medical Education	Rees, C., and Knight, L.	2008	*
Developing a set of quality criteria for community-based medical education in the UK.	Education for primary care	Cotton, P., Sharp, D., Howe, A., Starkey, C., Laue, B., Hibble, A., and Benson, J.	2009	*
Patient perceptions of their role in undergraduate medical education within a primary care teaching practice.	Education for primary care	Lucas, B., and Pearson, D.	2012	
Phenomenological analysis of patient experiences of medical student teaching encounters.	British Journal of Medical Education	McLachlan, E., King, N., Wenger, E., and Dornan, T.	2012	*

Table 6: Information about journal types, audiences and affiliations

Journal	Audience and Notes
Medical Education	Audience: healthcare professionals involved in education, but particularly international undergraduate, postgraduate and continuing medical education teachers, educators and researchers. Affiliated with the Association for the Study of Medical Education.
Journal of Medical Education	Preceded by the *Journal of the Association of American Medical Colleges* (1929-1950), then succeeded by *Academic Medicine* (1989- present). Affiliated with the Association of American Medical Colleges.
British Journal of Medical Education	Affiliated with Association for the Study of Medical Education. Journal continued as 'Medical Education' above.
Education for Primary Care	A Publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors. Audience predominantly postgraduate, rather than undergraduate general practice and primary care clinician-educators and academics e.g.: GP trainers, GP tutors and lecturers, Continuing Professional Development tutors, clinical and educational supervisors, postgraduate course organisers and training programme directors, associate Directors and advisers of postgraduate GP education, directors and deputy directors of postgraduate GP education
Medical Teacher	Affiliated with the Association for Medical Education in Europe (AMEE). Intended audience includes international health professional teachers and administrators.
British Medical Journal	The *BMJ* is a high impact international journal that publishes research from all specialties of medicine. It's audience include clinicians, researchers, and policy makers from around the world. The journal focuses on research which has an explicit practical applications or informs doctor's decision-making in the clinical, research, public health, and health policy settings.
Lancet	Medical publication from Great Britain, published in the USA. Audience: international health and medical professionals with an emphasis on research techniques.
British Journal of Dermatology	Affiliated with the British Association of

	Dermatologists. Audience: international – clinicians and researchers specialising in Dermatology.
The British Journal of general practice	Affiliated with the Royal College of General Practitioners. Audience is international family practitioners and primary care researchers. The journal started in 1953 as the '*College of General Practitioners' Research Newsletter*'. Then became the *Journal of the College of General Practitioners* in 1960 and the *Journal of the Royal College of General Practitioners* in 1967. Re-named the *British Journal of General Practice* or *BJGP* in 1990.

Table 7: Table 1 data divided into different categories of journal types

Education Journals

British Journal of Medical Education (7 texts 1973 – 2012):

A teaching course in general practice	BRIT.J.MED.EDUC.	Barber, J.	1973
The contribution of general practice to medical education: Expectations and fulfilment.	British Journal of Medical Education	Lloyd, M. and Rosenthal, J.	1992
Providing early clinical experience in primary care.	British Journal of Medical Education	Hampshire, A.	1998
Basic clinical skills: Don't leave teaching to the teaching hospitals.	British Journal of Medical Education	Johnston, B., and Boohan, M.	2000
Clinical clerkships: Students can structure their own learning.	British Journal of Medical Education	Smith, P., and Morrison, J.	2006
Thinking 'no' but saying 'yes' to student presence in general practice consultations: Politeness theory insights.	British Journal of Medical Education	Rees, C., and Knight, L.	2008
Phenomenological analysis of patient experiences of medical student teaching encounters.	British Journal of Medical Education	McLachlan, E., King, N., Wenger, E., and Dornan, T.	2012

Medical Education (16 texts 1978 – 2008):

Attitudes of medical undergraduates in Glasgow to computer-assisted learning	Medical Education	Murray, T., Barber, J., and Dunn, W.	1978

Teaching communication skills to pre-clinical medical students: a general practice based approach	Medical Education	Armstrong, D., Hicks, B., Higgins, P., and Weinman, J.	1979
Student experience in family medicine at McMaster and Glasgow Universities.	Medical education	Hannay, D R	1980
'Do as I say and not as I do'? An audit of clinical management in teaching compared with service work	Medical Education	Freeman G K	1981
The patient is the expert: a technique for teaching interviewing skills	Medical education	Kent, G., Clarke, P., and Dalrymple-Smith, D.	1981
An evaluation of medical student behaviours in communication	Medical Education	Irwin,W. and Bamber, J.	1984
The effects of Southampton's community experiences on student learning.	Medical education	Coles, C.	1985
General practice in the undergraduate curriculum: 20 interviews with Southampton final-year students	Medical Education	Mattson, B., Freeman, G., Coles, C., and Schmedlin, J.	1991
Community hospitals and general practice: extended attachments for medical students	Medical Education	Grant, J., Ramsay, A., and Bain, J.	1997
Community-oriented medical education in Glasgow: Developing a community diagnosis exercise	Medical Education	Davison, H., Capewell, S., Macnaughton, J., Murray, S., Hanlon, P., and McEwan, J.	1999
Patient-centred consultations: a comparison of student experience and understanding in two clinical environments	Medical Education	Thistlethwaite, J. E., and Jordan, J.	1999
A comparison of the educational opportunities on junior medical attachments in general practice and in a teaching hosptial: A questionnaire survey	Medical Education	Murray, E., Jolly, B. and Modell, M.	1999

Students' perceptions of the relative advantages and disadvantages of community-based and hospital-based teaching: A qualitative study	Medical Education	O'Sullivan, M., Martin, J., and Murray, E.	2000
Using real patients in problem-based learning: Students' comments on the value of using real, as opposed to paper cases, in a problem-based learning module in general practice	Medical Education	Dammers, J., Spencer, J., and Thomas, M.	2001
Students' conceptual model of a good community attachment	Medical Education	Silverstone, Z., Whitehouse, C., Willis, S., McArdle, P., Jones, A., and O'Neill, P.	2001
Is primary care 'real' medicine? Some medical students appear to think not.	Medical education	Jones, E., and Helbren, E.	2007
Teaching undergraduate psychiatry in primary care: the impact on student learning and attitudes.	Medical education	Walters, K., Raven, P., Rosenthal, J., Russell, J., Humphrey, C., and Buszewicz, M.	2007
Does the presence of medical students affect quality in general practice consultations?	Medical Education	Price, R., Spencer, J., and Walker, J.	2008

Medical Teacher (2 texts 1996-2002):

Early patient contact for medical students: an exploration of GP teachers' perceptions	Medical Teacher	Mowat, D. and Hudson, H.	1996

Student access and use of IT during general practice attachments	Medical Teacher	Regan, M., O'Neill, P., and Whitehouse, C.	2002

Education for Primary Care (5 texts 2003-2012):

Developing communication skills: A selected study module for first-year medical students using an educational constructivist approach	Education for Primary Care	Nicholson, S., Rana-Masson, S., and Cushing, A.	2003
The impact of expanded general practice-based student teaching: the practices' story.	Education for Primary Care	Quince, T., Benson, J., Hibble, A., and Emery, J.	2007
A comparison of clinical content between structured specialty teaching sessions and teaching in routine general practice consultations.	Education for Primary Care	Bryant, P., Berlin, A., Coppola, W., and Jones, M.	2008
Developing a set of quality criteria for community-based medical education in the UK.	Education for primary care	Cotton, P., Sharp, D., Howe, A., Starkey, C., Laue, B., Hibble, A., and Benson, J.	2009
Patient perceptions of their role in undergraduate medical education within a primary care teaching practice.	Education for primary care	Lucas, B., and Pearson, D.	2012

Clinical Journals

BJGP (4 texts 1980 – 2002):

Medical student attitudes and general practice.	The Journal of the Royal College of General Practitioners	Fowler G H	1980
Undergraduate teaching in the community: can general practice deliver?.	The British journal of general practice	Wilson, A., Fraser, R.,	1996

		McKinley, R., Preston-Whyte, E., and Wynn, A.	
General practitioner teaching in the community: a study of their teaching experience and interest in undergraduate teaching in the future.	The British journal of general practice	Gray, J. and Fine, B.	1997
Attitude of medical students towards general practice and general practitioners	British Journal of General Practice	Henderson, E., Berlin, A., and Fuller, J.	2002

BMJ (4 texts 1974 – 2005):

Patients' attitudes to medical students in general practice	British Medical Journal	Wright, H.	1974
Can students learn clinical method in general practice? A randomised crossover trial based on objective structured clinical examinations.	BMJ (Clinical research ed.)	Murray, E., Jolly, B., and Modell, M.	1997
Influence on general practitioners of teaching undergraduates: qualitative study of London general practitioner teachers.	BMJ (Clinical research ed.)	Hartley, S., Macfarlane, F., Gantley, M., and Murray, E.	1999
Impact on patients of expanded, general practice based, student teaching: Observational and qualitative study	British Medical Journal	Benson, J., Hibble, A., Fanshawe, T., and Emery, J.	2005

Lancet (1 text 1976):

Computer-assisted learning in undergraduate medical teaching.	Lancet	Murray, T., Barber, J., and Hannah, D.	1976

British Journal of Dermatology (1 text 1993):

Undergraduate teaching in dermatology and general practice [9]	British Journal of Dermatology	Hay, R.	1993

Appendix 5 – Parker's Framework

Parker's approach is outlined below (Parker, 2002; Shaw, 2008). My own analysis was informed by Andersen (Andersen, 2003) and Howarth (Howarth, 2000). However, other authors who have used a Foucauldian approach to discourse analysis in the fields of medical education and primary care research, have drawn upon this analytical framework:

Criteria for distinguishing discourses	Description
Discourse is realised in texts	As the world around us is textual, we need to treat objects of study (e.g. documents) as texts which are described and put into words
A discourse is historically located	Discourses are embedded in history and should be considered in relation to time. We need to explore how and where discourses emerge and describe how they change
A discourse is a coherent system of meanings	Discourse is made up of groups of statements that present a particular reality of the world. The task of the analyst is to map the world as discourse represents
A discourse is about objects	Using language means referring to objects and representing them in particular ways. Hence, we unpick what objects are referred to and how they are talked about
A discourse contains subjects	As discourse addresses us in particular ways and allows us to perceive ourselves in certain roles, we need to identify the rights we have to speak in relation to any discourse
A discourse refers to other discourses	Describing discourses necessarily involves the use of other discourses. Contrasting different ways of speaking helps to disentangle this
A discourse reflects on its own way of speaking	Each discourse comments upon the terms it employs, referring to other texts to elaborate. Hence, there is a need to reflect on the terminology used
Discourses support institutions	Discourses involve the reproduction of institutions. Analysis involves identifying institutions that are reinforced or subverted when a discourse is used
Discourses reproduce power relations	Discourse and power are intimately related so we need to look at which categories of person gain and lose from employment of a discourse
Discourses have ideological effects	Different versions of how things should proceed can coexist and compete within discourse. Hence, there is a need to show a discourse connects with other discourse to sanction control

Appendix 6 – Poster

This poster was presented at the Society of Academic Primary Care Conference in Dublin 2016. I thought it might be useful to include as a visual summary of some of the analytical categories discussed within this thesis.

General Practice Placements in Medical Education Research

Dr Sophie Park*, Dr Mark Newman** and Dr Caroline Pelletier**

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1. Background

This study examines published research about undergraduate medical education in the UK general practice setting. It uses a Foucauldian approach to discourse analysis, questioning how general practice placements are characterised; and research justified. These questions concern the treatment of knowledge and subsequent power relations, providing a critical lens to examine what is made 'thinkable' (and 'unthinkable') within this discursive field. At present, there is a crisis recruiting trainees to GP careers[1,2,3], thought to be related to students' undergraduate experiences[4]. There is also a lack of GP tutors in the context of competing demands between service and teaching duties. The existing field of research, although substantial[5], has been critiqued[6].

2. Research Questions

Within published research texts about UK general practice placements:

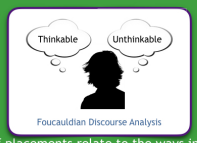
- What is said to be taught and learnt in general practice placements?
- How is the production of research justified?

3. Method

This analysis produces a topography or map of how general practice placements are characterised. Published research texts from 1960s-present were examined.

Four categories of analysis were used[7,8]:

- how the object of general practice placements are characterised;
- subject positions made available;
- concepts or logics; &
- strategic treatment of placements.

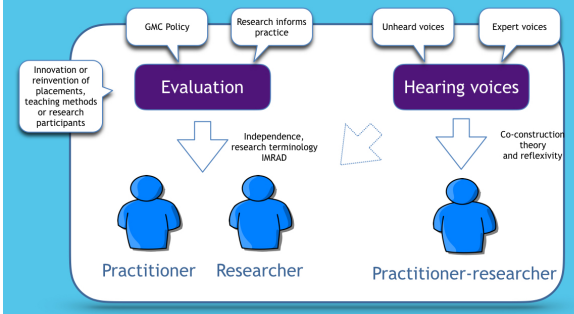


This analysis considers how the characterisation of placements relate to the ways in which research is justified in these texts. This helps us to consider thinkable (and unthinkable) existing and future ways of researching and characterising placements.

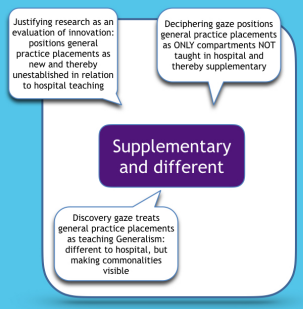
4. Results

Tensions exist within this discursive field. The dominant way in which research is justified is as evaluation. This positions the researcher as an evaluator. The dual role of the researcher-practitioner is predominantly separated, positioning the evaluator as external, rather than contextualised. Strategically, general practice placements are positioned as supplementary to hospital teaching. The texts justify research as evaluation of 'innovation', thus treating general practice placements as new & un-established. A deciphering gaze treats general practice as supplementary, teaching what is NOT taught in the hospital. While a discovery gaze still produces general practice as 'different', it makes visible the commonalities between general practice and hospital placements. A discovery gaze legitimates the professional work of the GP, characterising what is taught and learnt as workplace-based learning, rather than characterising placements as pre-determined by hospital-based curricula.

Justification of research

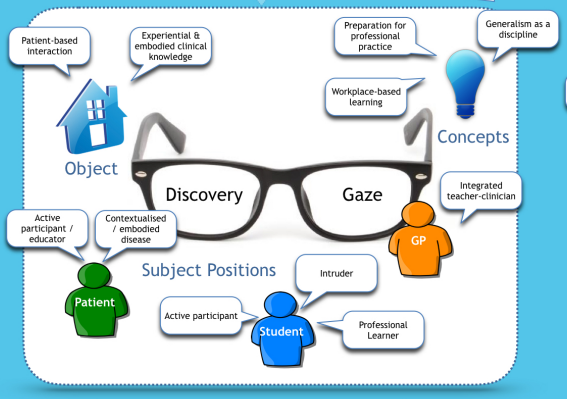


Strategies

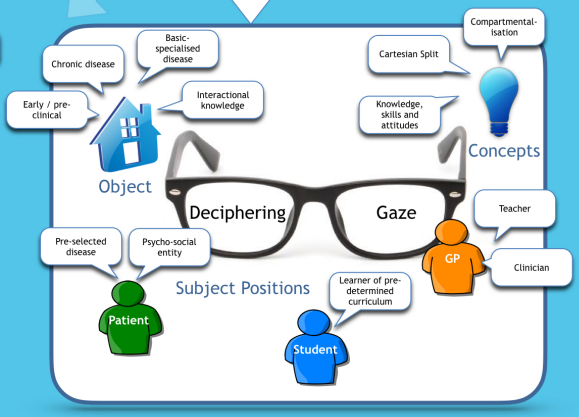


Michel Foucault

In Birth of the Clinic[9], Foucault used the concept of 'gaze' to examine how 'the body' and 'the clinic' were made thinkable over time. In Archaeology of Knowledge[10], Foucault examined the ideology of 'science' as a system of formation (objects, subject, concepts and strategy), treating science as one possibility among others[11]. Foucault treats texts as a social practice. His approach enables us to analyse relations of power and how they are constructed and maintained. It makes visible how particular ways of characterising placements are made thinkable, and others unthinkable.



Characterisation of General Practice Placements through a Discovery Gaze



Characterisation of General Practice Placements through a Deciphering Gaze

5. Conclusions

A gaze of discovery positions the student-patient encounter as contemporaneous with the clinician. This integrates the work of the tutor as clinician-teacher, but sometimes positions the student as an intruder or disruption to service. What is taught & learnt in placements is characterised as workplace-based learning. In contrast, a gaze of deciphering characterises placements as compartments of knowledge (e.g. chronic disease or communication skills), or as 'early' / 'basic', pre-determined by the curriculum to supplement hospital-based teaching. This splits the available positions for the patient (e.g. mind-body) and the GP as 'teacher' OR 'clinician'. Mapping the 'thinkable' enables consideration of the 'unthinkable. If the researcher was justified as integrated researcher-practitioner, or as making visible (rather than evaluating), the dual role of the researcher might be made more legitimate. This might also make more legitimate the characterisation of placements as workplace-based learning, rather than pre-determined knowledge compartments. Shifting this discursive field, could have positive implications for students' attitudes towards general practice careers; help maintain GP tutor faculty; and develop the field of research about general practice placements.

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